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TRANSACTIONS

OF THE

THIRTY-THIRD SESSION

OF THE

American Institute of Homœopathy.

HELD IN MILWAUKEE, WISCONSIN, JUNE 15, 16, 17, 18, 1880.

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PREFACE.

THE Transactions of the Thirty-third Session of the American Institute of Homœopathy, are herewith presented in one volume, consecutively paged, fully indexed, and substantially bound in cloth.

The arrangement of the Reports and papers of Bureaus and Committees is similar to that of preceding volumes. The Constitution, By-Laws, and Catalogue of Members are placed at the close of the volume, instead of at the end of the Proceedings proper.

A brief history of the organization of the Institute with a list of its Officers to the present time has been printed as an appendix.

All of which is respectfully submitted.

J. C. BURGHER,
General Secretary.

PITTSBURG, PA., September, 1880.

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AND

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OF THE

THIRTY-THIRD SESSION

AND

Thirty-seventh Anniversary

OF THE

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PROCEEDINGS

OF THE

THIRTY-THIRD SESSION

OF

THE AMERICAN INSTITUTE OF HOMŒOPATHY.

HELD AT MILWAUKEE, WISCONSIN, JUNE 15, 16, 17, 18, 1880.

FIRST DAY.

MORNING SESSION.

T. P. WILSON, M.D., *President: Ladies and Gentlemen:* The Thirty-third Annual Session of the American Institute of Homœopathy is here now convened for the transaction of business. The proceedings will be opened by the Rt. Rev. R. E. Wells, D.D., Bishop of Wisconsin.

Prayer was then offered by Rt. Rev. R. E. Wells.

T. P. WILSON, M.D., *President:* The Institute will now be in the hands of the chairman of the Local Committee of Arrangements for a short time. Dr. Olmstead, of Milwaukee, will now take charge of the Institute.

DR. OLMSTEAD: Gentlemen, allow me to introduce to you our Mayor, the Hon. T. H. Brown.

THE MAYOR'S ADDRESS.

Mr. President and Members of the American Institute of Homœopathy: You are assembled in Milwaukee upon the invitation of the Common Council extended to you one year ago. On be-

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half of the Common Council and the city I extend cordial greeting, and venture to hope that your sojourn may be so agreeably and profitably spent that the acceptance of the invitation will not be regretted.

Merchants, manufacturers, the tillers of the soil, ministers of the Gospel,—all trades, professions, and callings have their organizations. Representative men from all parts of the country assemble in convention, relate their experiences, compare the results of each other's labors, and thus the knowledge of the experiments, the "provings," the achievements of each is secured to all.

Whatever is useful in the arts, the sciences, in mechanics, in agriculture, in every branch of human endeavor, is sifted out by this process, and thus practical knowledge is disseminated, the slavery of prejudice, superstition, and ignorance abolished, and mankind improved and elevated in character and condition. But of all the grand vocations which command the earnest thought and toil of man there is none more honorable, more elevated, more comprehensive, more useful to the world than that to which you have devoted yourselves,—the art of preserving life and health.

The physician's field of labor is inexhaustible. Its boundaries are the habitable globe. Wherever he goes he finds man subject to like infirmities, sorely in need of his attention, his care, his kind and cheerful words.

The physician's usefulness is not terminated by death. His grand achievements live after him and continue a blessing to mankind generations after his name has been enrolled with Pythagoras, Hippocrates, Galen, Boerhaave, Cullen, Blane, Jenner, Hahnemann, and many more great benefactors of the world.

Doctors, expressing the desire that your convocation may be harmonious, that it may result advantageously to the profession you cherish, and to those sublime purposes to which your lives and labors are consecrated, I again extend to you the welcome and hospitalities of the city.

Dr. C. C. Olmstead: Allow me to introduce to you Professor Danforth.

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PROFESSOR DANFORTH, on behalf of the State Association, spoke as follows:

Mr. President and Members of the American Institute of Homœopathy: Our Mayor has cordially welcomed you to Milwaukee, —this unpretending, though generous City of the West, clustering here on the sunset side of the great lakes; renowned for its beauty of scenery, its elegant homes, its real wealth, and satisfied life. It is made my pleasant duty to bid you welcome to Wisconsin,—and so, I extend to you all a fraternal greeting. Forty years ago there were but 30,000 persons living within our borders; now there are upwards of 1,500,000, who have pitched their tents among us, giving us, through summer and winter, peace and war, for forty years an average immigration of 3000 a month or 100 a day. This tidal wave still flows on, and this year with increasing ratio. Our State sustains an unimpeachable character for intelligence, industry, progress, patriotism, and, I may add, wealth; a soil of unsurpassed fertility, immense pine forests on our north; iron mines, lead, zinc, and other precious metals scattered in rich profusion, each, all contribute to repay the toil and endeavor of life, while they occupy and ennoble the toiler. In the name, then, of our commonwealth, of its industry, intelligence, patriotism, and progress, in the name of the Wisconsin Homœopathic Medical Society, and of the 175 homœopathic physicians practicing their profession here, I bid you a hearty welcome, a thrice hearty welcome, to this Switzerland of America.

T. P. WILSON, M.D., *President:* In behalf of the American Institute of Homœopathy I have the pleasure of accepting your hearty words of welcome.

Let me assure you that those words have sunk deep within our hearts and caused upon a thousand chords responsive vibrations.

But yesterday, as it were, your streets were thronged with the broken, bloodstained but enthusiastic ranks of our nation's honored defenders. Over their heads you hung the Stars and Stripes. Upon their brows you placed garlands of flowers.

To-day your beautiful city is again invaded, but not by armed

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legions of soldiers. Not as the conquering heroes come, not with songs of war or beating of battle-drum, but as under a snow-white banner upon which is written the song of Bethlehem's angels, "Peace on Earth, Good-will to Men," so have we come and are made thrice welcome.

To many of us there is here opened a new world of existence. We have followed human civilization in her pathway full many a league toward the setting sun, and, lo! the touch of her magic wand has transformed everything into shades of beauty.

Behind us the broad expanse of an inland ocean and before us the fertile fields of Wisconsin. We behold her like a bride adorned for her wedding, with your beautiful city as the brightest jewel upon her forehead. We have come to woo her for a little while and to fix in our memories, that shall never die, some precious recollections of the brightness of the diadem she so proudly wears.

Milwaukee's fame we have heard from afar. Her sons and her daughters have contributed no small share to the common glory of our country. We have come to sit a little while by your firesides and make what may seem to be a brief acquaintance with you and yours.

But believe me, while our hearts beat responsive to human emotions we will cherish the recollection of this glad hour, and in turn will make you welcome when in other lands your tired feet shall touch the thresholds of our beloved homes.

THE PRESIDENT: It will be necessary for us to adopt an order of business. This order of business we are to follow for the next four days. The Secretary is present, and places in your hands such an order of business, subject to your approval or otherwise. What is the wish of the Institute regarding this order of business?

DR. FOOTE, of Conn.: I move you that the order of business presented by the Secretary be adopted.

DR. T. L. BROWN, of Binghamton: I second the motion.

DR. E. M. KELLOGG, of New York: I would propose an amendment, and that is that the Bureau of Organization, Registration, and Statistics should first report. Heretofore that bureau

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has always been among the very last to report, at the close of the session, when the membership is thinned out. Now, this year we have an unusually valuable report, which we want to lay before the Convention early in the session. As an amendment, if it is in order, I would move that the selection of the time and place of the meeting and of the officers be made the order of business at the hour of noon on the third day. If it be deferred to the last day the attendance is small. Many of those who have attended the early session of the Institute have left, especially those who live at a distance, and that is the reason that I make this motion for these two changes in the order of business.

DR. MCCLELLAND, of Pittsburg: I second these amendments.

DR. FOOTE: I accept the amendment.

THE PRESIDENT: Dr. Foote moves the adoption of the order of business subject to the amendments suggested by Dr. Kellogg, of New York.

DR. DAKE, of Nashville, Tenn.: *Mr. President:* It should be understood, with reference to this report of the Bureau of Organization, Registration, and Statistics, that it follows the report of the Necrologist.

The question being on the adoption of the order of exercises presented by the Secretary, subject to the amendments suggested by Dr. Kellogg, it was agreed to.

DR. T. P. WILSON, of Ann Arbor, Mich., *President of the Institute,* then delivered the

ANNUAL ADDRESS.

Ladies and Gentlemen, Members of the American Institute of Homœopathy: One-third of a century has elapsed since this society was first organized. A generation of men has passed away since that event, and we of to-day are practically a new race, but the legitimate successors and lawful heirs of the noble men who founded this organization. Men die, but principles remain, and the truth lives forever. And it must be no small gratification to our honored veterans, who have seen the past as they now behold the present, to find the doctrines which they espoused so long ago maintaining themselves with a vitality that

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betokens no advancing senility. And let me here, first of all, in your behalf, as is my duty and my pleasure, extend to these men who are yet with us to admonish and encourage us the friendly hand of greeting. And let me also send words of good cheer to the members of our veteran corps who in their distant homes, and unable to be with us on this occasion, are looking with dimmed yet anxious eyes upon our proceedings, and recalling, it may be with saddened yet pleasant memories, those early times when they watched over the cradle of our cause; and let us hope that they may have reason to rejoice in the knowledge that we are here gathered around the camp-fires of our tribe, as they were wont to gather and to rejoice in days of yore, and that over us all still floats the unsullied banner of *Similia*. If the advent of homœopathy into the world's arena constitutes, as clearly it does, one of its most important medical epochs, and one which beyond doubt will span and fill the centuries that are to come, it is not likely that we may note much of its progress within the short space of a year.

Two facts of importance hide from our eyes the real progress we are making. The first of these is the cessation of hostilities that were formerly waged against us. Our fathers know what battles have been carried on that our cause might maintain its footing. How sharp, bitter, and persistent has been the struggle with the enemy in high places and in low! What scorn, what denunciations, what ridicule have been heaped upon all we hold dear! It were well that we bore these things in mind when we feel inclined to complain.

To-day we are securely intrenched, and our ensign floats over all the field. We are no longer rudely assaulted and beaten back by the hands of ignorance. We are not now overwhelmed by numbers, and our rights wrested from us because we happen to be in the minority. Those who a few years ago were our violent opponents are to-day our honorable competitors. And while we have not in all respects yet reached the full measure of our righteous demands, yet as citizens of the commonwealth, as scientists, and as members of the honorable profession of medicine, the representatives of homœopathy in the United States have reason to be proud of their standing. And so it happens,

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because we are no longer sharply opposed, we fail to see how upon every hand we are spreading and taking root. But the fact is nevertheless demonstrable.

The second fact which tends to make our progress less perceptible to the eye is that our work has become so widely distributed over this almost boundless country of ours. I can well remember when there was but one practitioner of homœopathy in all the State of Ohio. He was a veritable nondescript, a wonder in the eyes of the people, and if half that is told of him were true he must have been able to discount the prophets and apostles of old in miracle-working. One after another joined this good man in his noble work, and every fresh recruit was a fresh cause for surprise. A well-known order of phenomena is the transition we experience in passing from smiles to laughter, and from laughter to tears. It was so with those who saw the rise of our cause. At first they smiled at its seeming harmless vagaries, then they laughed when its followers rapidly multiplied, and at last they wept when they saw the multitude that followed after it with such boundless enthusiasm. If you take an electric discharge from a single point it will be keenly, perhaps painfully, felt; if you distribute that charge doubled in power over a broad surface it will scarcely be noticed. So if you had in this fair city but one of the followers of Hahnemann, his very footprints would be watched and numbered, but as it is to-day you might be puzzled to find a chamber of sickness in which his gentle footfalls are not heard and his divine ministrations of healing not enjoyed. Therefore the wonder ceases.

By a curious provision of your Constitution, the President, in his annual address, is chiefly confined to the subject of "the progress of homœopathy during the past year." As this limitation was applied only a few years ago under a peculiar excitement, now happily passed away, and as its presence in the Constitution of your body is not creditable to your intelligence or the abilities of your presiding officers, I shall take occasion before I close to recommend a change in the article referred to. And when I, your present and most highly honored President, shall have reached the past presidential position, it may be concluded that all danger against which this clause was put as a warning will

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be happily passed. My successors might safely be left to their own judgments as to the nature of the topics they will discuss in their annual addresses. Under that established limitation, I beg to call your attention to the subject assigned, viz.,: the progress which homœopathy has made during the past year. A prosaic relation of the facts which show that our cause is advancing will certainly fill the letter of the law, but there is a demand for something more, and that something is a demonstration of the underlying principles which constitute the philosophy of all true progress. It is as easy to see why the cause of homœopathy has gone steadily forward from its inception until to-day, as it is to see why the human race has developed out of barbarism into a state of civilization. The forces which lift us up on to a higher plane of development, socially, morally, and politically, would not be true to themselves if they were to leave the medical profession to wander on in the ancient paths of darkness.

The birth of homœopathy did not signal an epoch of medical reform merely. It was and is in all respects an epoch of revolution. A failure on the part of some to fully grasp this fact has resulted most disastrously to individuals and greatly hindered our cause. If men would only remember the sad fate of Lot's wife, if they would only recall the foolishness of the Israelites in their longings for the leeks and the fleshpots of Egypt, there would be in our ranks to-day less solicitude for the welfare of false and obsolete systems of practice, and a more jealous and zealous care for the honor and advancement of homœopathy. But in spite of this we have been and still are advancing. And the ratio of advancement has been in direct proportion to the degree with which we as a school have adhered to the principles of homœopathy as taught by Samuel Hahnemann; and this, not because they were taught by Hahnemann or were any better because he taught them, but because those principles are in themselves true, and therefore unalterable. Hahnemann's relations to the doctrines of homœopathy were purely incidental. Had he not been born when he was and fitted by his studies to discover and proclaim the truths of homœopathy, then another in answer to the demand of the law of evolution would have stepped in where he stood, and done his work and received his glory.

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It was in some sense a cataclysm, which marked the advent of medical truth into the world, and which gave to mankind its first knowledge of the existence and nature of a therapeutic law. A new era dawned, and then the forward march of order began, and it will ever continue until the chaos of empiricism is swallowed up and destroyed.

It must be conceded that Hahnemann thoroughly understood the problem with which he was dealing, so far as it related to the system of medical practice then in vogue. No man better than he understood the utter falsity of the theories and methods of his predecessors and contemporaries. This will be cheerfully acknowledged by all. It was not necessary that he should grasp, even after years of careful study and experiment, the whole scope of his discovery. I say it was not necessary; but if since his time there has risen a mind in the medical world possessing a deeper or truer insight into the arcana of therapeutics, he should be made to stand forth that we may know him and crown him. And what, alas! if he whom we are seeking after should prove to be one of the modern gods of this bastard system taught by a Ringer, or a Phillips, or a Bartholow! Hahnemann at least knew what he was striving to get away from, though he may have but dimly guessed whither his new path was leading him. It cannot be charged upon him that he was ever knowingly false to the principles of truth which were revealed to him. He made no compromise with error. No more did he apologize for ignorance. With the inspiration and fervor of genius, he adored that only which he saw to be true. You cannot conceive of such a mind as his framing an apologetic rule like this.

The homœopathic law is coextensive with disease, but if any among us shall resort to any medical means other than those pointed out by the law *similia similibus*, the fault shall lie first of all at the door of our Materia Medica on account of its incompleteness, or, failing to make that excuse good, then it must be due to a want on the part of the physician of a sufficient knowledge of the remedies already possessed by our school. In other words, and applied to other things, a man may not steal or commit murder according to the law, but if he does these things it must be because the authority of the government is

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weak, or the person so violating is presumably ignorant of the law.

Men have what they facetiously call statutory laws, and they pile them up in vast and numberless tomes, and there they lie, some of them living, many of them dying, most of them dead. But nature has no laws but such as live and act without cessation. When her laws cease to act, if that were possible, they die and are dead forever. And since they are living, there is no evasion of them or successful compromise with them. Hahnemann sought for no compromise. And this is what I mean when I say we are advancing just in proportion as we adhere to the truths discovered by Hahnemann, and follow the principles laid down by him in the conduct of his professional life. Upon this point there are those who needlessly deceive themselves.

To revive issues that are dead, to reassert what has been successfully denied, to declare that true which has been a thousand times proven to be false, to cling to those things which we have completely outgrown, to continue those practices which have become obsolete, to go back to the dead past instead of going forward to the living future is not progress. Neither is it progress to go forward in a circle, while nothing can be worse than facing squarely about and attempting to retrace our steps. Dogs may return to their vomit, and sows to their wallowing in the mire, but the science of medicine, as developed and fostered in the homœopathic school of to-day, can never return to the chaos from whence it came forth.

It was neither a misfortune nor a mistake when the homœopathic system was founded as a distinct and independent organization. It was a necessity, and through our separate maintenance as a medical school has come all that we have achieved for medical science. Those who have vainly tried to blend the issues between us and our opponents, and those who have decried our efforts to maintain those issues because they were vital to truth itself, and those who have charged upon us the crime of "sectarianism" when we manfully stood up for that which was our own, have been everywhere justly overwhelmed with confusion and disappointment. We stand to-day represented in every portion of our commonwealth by thousands of intelli-

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gent practitioners, and by hundreds of thousands of intelligent and wealthy patrons. Now the maintenance of a proper *esprit du corps* of so large a body is a matter of no small importance. Why have we thus far stood together? Simply because we had something for which we might stand. Have we less to-day than we had in former years? The responsibilities which rest upon us as the national representative body of the homœopathic school are neither few nor small. What we may do or say will, like the patriot shot at Concord, be heard round the world. If we shall dare to compromise or surrender aught of that which is true, we will be recreant to duty, and unworthy the trust confided to our care. If, however, we shall strike the keynote of advancement full, clear and loud, there will be many a fainting heart cheered, and along the whole line you may look to see the flashing of arms in serried ranks moving to fresh victory. But should we utter discordant notes, or give uncertain sounds, it would mantle with shame a vast multitude of faces that for years have glowed with the light of hope and the inspiration of truth. I tell you that, though I am counted an enthusiast, I felt ashamed of my coldness for a cause that had lain so long and closely to my heart when, a few weeks since, I stood in the presence of threescore ladies, drawn together by a common impulse, whose hearts had been touched by the hand of compassion for suffering humanity. And when I heard them say what they were willing to do for our cause, what sacrifices they would make that God's poor might have their diseases cured, and when I saw their sublime faith in the therapeutic powers of our Materia Medica, and the almost boundless enthusiasm with which they indorsed the principles and practice of the homœopathic healing art, I felt to thank God with all my heart and to take fresh courage, for the truth cannot be bartered away nor spoiled of her heritage so long as she is enshrined in the hearts of humanity.

I beg now to call your attention to another most important fact. We have been advancing because the philosophy of our art is in consonance with the general advancement of science. During nearly a century of growth we have never been checked at a single point by any fresh discovery in the whole domain of science. I need not call your attention to the fact that empirical

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medicine has been, time and again, suddenly thrown back upon its haunches by the revelations of physiology, and of chemistry, and of microscopy, and of kindred subjects. I need not point out to you how, in spite of such revelations, the most absurd practices have been continued and taught by that same empirical school. On the other hand, the homœopathic school has found that not only its great central law of cure, but every corollary springing out of that law, has received the most cordial indorsement at the hand of kindred sciences. There can of course be no knowledge of a therapeutic law until we have come to a just comprehension of the true nature of disease. It has been most absurdly stated that Hahnemann rejected pathology. On the contrary, we assert that he was the most profound pathologist of his age. What he did reject was the unscientific theories and the unmeaning jargon of those who assumed to teach pathology. What he especially rejected was the assumption that the tissue changes produced by disease was the disease itself or was the thing to be treated by the intelligent physician.

Hahnemann taught us that back of all functional and tissue change was the original disturbing force, and that it was to this force, or these forces, which, in every case of disease, brought about the changes recognized, that the physician must apply his regulative and controlling art. And Hahnemann taught us another equally important fact, namely, that the agents which are employed in the cure of disease are not to be judged merely by their physical and chemical qualities, but by the forces resident in them. And he taught us, moreover, how those forces were to be studied and understood. It seems trite to say these things to you who are veterans in the work of practicing and teaching homœopathy; but, my friends, these things are not understood, simple as they are, certainly not by those who oppose us, and, alas! often not understood by those who assume to represent us. The cause of this misfortune cannot be fixed upon any one source. We may charge it upon preceptors that they do not set the right example before their students, and, remembering the old adage, "like priest like people," we do not wonder that students imbibe the most erroneous theoretical and practical ideas at the very outset of their career, and that they live only to repeat upon a larger

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scale the evil practices of their preceptors. We might charge it upon our current and general literature that it is sadly tainted with empiricism, and that it is guilty of offering sugar-coated error to the public in place of the plain and priceless truth. We might charge it upon our medical colleges that they fail to teach their students that which is most desirable they should be taught, and that they allow candidates to graduate who have no proper conception of the philosophy of medical science, and have not been drilled into the true methods of homœopathic practice. If hundreds of such are being turned loose upon the profession yearly, while the old original stock of practitioners is dying out, it will not be difficult to foresee the result of another third of a century to homœopathy in this country. It is well known to you, my friends, that every doctrine and practice peculiar to our school has been fiercely and rudely assailed by those professing to be members of the homœopathic profession. If each of them had gained their points, there would literally have been nothing left of us to-day. We cannot afford to be optimistic in the face of such startling facts. Least of all can we afford to lull ourselves to sleep with the songs of peace. As we are attacked, at home or abroad, we must attack in return. Of what use to us is peace purchased by the selling of truth?

> "Better war, loud war, by land and sea,
> War with a thousand battles and shaking a hundred thrones."

The past year has been marked by an unusual amount of controversy. No one, I think, should call in question the right of either party to a full, fair, and candid expression of their views. Our only hope of present safety and future progress lies in continued agitation. But if I am to report upon the progress of homœopathy, it becomes my duty to say that we have been greatly hindered by controversies of a purely personal character, and it will be noticed that our literature will not be greatly enriched by contributions of this sort. A continuance of this is to be deprecated. My venerable predecessor, Dr. Small, in his presidential address, in 1873, gave utterance to the following words:

"The power of the press is everywhere revealed, and in the service of truth it builds up human interests. It should never

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be the willing generator of puerile strife, but the propagator of noble principles. In medicine it should be the channel of truth, of new discoveries, and practical observations. A medical journal is out of its legitimate sphere when it becomes the propagator of doctors' quarrels, throwing broadcast personal invectives, dogmatic implications, and insinuations of a personal nature."

Most heartily should we indorse these words, and I have placed them here that they may again be read and better heeded. There is such a wide field of future work before us, and it is so resplendent with the harvest of truth that we cannot, my friends, afford to exhaust our energies in any other direction or upon any other cause. And I beg to call your attention to the fact that the general advancement of science is constantly widening our sphere of action. Who would have thought a few years ago what the microscope might do for us in the improvement of a certain class of triturations? Who would have guessed what a widespread interest might be created in these investigations? Molecular physics has received a new impetus from what has been already done in this direction by our Bureaus of Microscopy and Materia Medica, and it has also greatly enlarged our knowledge of both what is done and should be done by our pharmaceutists in their preparations of triturations. This department of pharmaceutical work may be said to have gone a long way forward within the past two or three years. It has been thought by some that the recent work of our microscopists has tended to cast a shade of doubt upon the validity of our so-called high attenuations. Nothing can be further from the truth than this. In the first place, the microscopical work alluded to has but just begun, and has not assumed a finality upon any fundamental question. In the second place, it is not probable, I may perhaps say not possible, for any future revelations of the microscope to affect in any special degree the question of dynamics. The microscope deals with drug forms; it is left for another department to deal with drug forces. And here we find a wide field opening before us. We are to-day studying force under entirely new conditions. Those marvellous instruments known as the radiometer of Professor Crooke and the tasimeter of Mr. Edison are revealing to us a new world of thought. And I can easily imagine how a knowledge

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of them would have gladdened the heart of Hahnemann and would have helped him to a ready explanation of the mystery that naturally hung about his thirtieth centesimal potencies, to say nothing of higher attenuations. My friends, we have to discover a fact before we can explain it. The explanation, however, does not always follow hard upon the heels of the discovery. On the contrary, it lays often a long way behind.

The power of attenuated remedies to cure disease was a fact discovered by Hahnemann, and it is a fact, demonstrated in the United States alone not less than a hundred thousand times every day. The explanation of this comes too slowly. But it comes nevertheless, and we find that every fresh discovery in the field of dynamics has added to that explanation. I am not speaking of any particular form of attenuation, for to every mind the sixth and the six thousandth are equally in want of a philosophical explanation of their curative capabilities. But upon this point I need go no further.

I come now to speak of another cause of our progress, namely, the enlargement and perfection of our educational work. The homœopathic colleges of the United States are taking high rank among the best educational institutions in the country. It is not the fault of some of them that they do not take yet higher grounds. It is the fault of the profession, which will not patronize as it should colleges that demand better scholarship. It is to be regretted that the Intercollegiate Congress has met with so much to discourage its action. For the honor of our cause, let us hope that it will yet succeed in effecting a sodality among our colleges, and that together and in harmony they may carry on our educational work in accordance with the demands of the times. And I must especially urge that, in the matter of final examinations for graduation, there is much need of reformation. A competent board of examiners, of disinterested persons, for each college, should be appointed, and this board should conduct a very full and complete examination into all strictly medical subjects, and the result of such examinations should be final as to graduation. There is a gross impropriety in the faculties passing upon their own work, and their virtues should not be so severely tested by asking them to cut down at one fell blow both

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the number of graduates and the cash receipts. This is too much for poor human nature to bear.

Two of our colleges have fairly and honestly met the demands of this body by requiring a preliminary examination, and they have done more in requiring attendance upon three full courses of lectures, in one case eight months each and in the other nine months each before graduation. This, I think, we may call substantial progress. Several of the remaining colleges will make the same requirements beyond a doubt within the next year or two, and let us hope all of the homœopathic colleges will be upon a like high plane within a comparatively short period. The past labors of your intercollegiate committees have contributed much toward these desirable results.

Our current and general medical literature demand at my hands words of the highest commendation. Of making many books and publishing many journals there is no end, and let us earnestly pray that there may never be such an end in our school. We can no more live and grow as a medical school without flowing constantly into our professional body a generous and fresh current of literature than we could exist as individuals without daily food and without fresh and healthy blood flowing in our arteries and veins. All honor to the intelligence and enterprise of the authors and publishers who give us yearly such fresh and generous draughts.

It is well known to most of you that but a small part of the writings of Samuel Hahnemann has been given to the world. His *Materia Medica Pura*, his *Chronic Diseases*, his *Lesser Writings*, and, above all, his *Organon of the Art of Healing*, have long been the classics of our literature. I am credibly informed that a large amount of unpublished manuscript is yet in the hands of his heirs. I have in my possession a pretty full catalogue of what those writings comprise. It has been thought desirable by many that these should be given to the world. I am heartily of that opinion. I would like to place in the hands of a committee such documents as have come into my possession in reference to this matter, and to have that committee report upon the subject at an early date.

I beg to recommend the amendment of Section 1, Article III,

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of the Constitution, so that the President shall be left free to choose the subject of his annual address, as is the custom in all similar scientific bodies.

I beg, also, to call your attention to the second resolution passed June 8th, 1854, as casting an uncalled-for aspersion upon our homœopathic Materia Medica, and offering a needless apology for ignorance. By persons inimical to our cause it is often quoted to our hurt. It is misleading, and therefore injurious in its effects upon the public mind. When we have said "that we regard the homœopathic law as coextensive with disease," we have set up a standard that is not ideal but real and practical, and it should not be concealed under apologetic phrases; neither should it be lowered in the same breath to suit those who are lacking in knowledge or in devotion to principle.

It is proper perhaps that I should report to you that I was present as a delegate at the last meeting of the American Public Health Association at Nashville, Tennessee. This large and important body of scientists is wielding a great influence over this entire country. I am assured that delegates from this body would be cordially received by the Association, and I would urge upon all of you as individuals to take a personal interest and if possible a personal part in the proceedings of this body.

A question of paramount interest to us here presents itself. Nearly twenty years ago the war of the rebellion broke out and a vast body of men were called into military service. These men of necessity demanded a large amount of medical attention. From the surgeon-general down to the humblest regimental surgeon there were employed a small army of medical men, whose posts of honor and emolument were eagerly sought after. It is well known to you that all these honorable and responsible positions were filled exclusively from one medical school. It was in vain that the representatives of the homœopathic school sought for employment and recognition. The most bitter opposition was set up against, and the most foolish and flimsy excuses offered by the government for excluding us from the surgical staff of the army and navy. All this is passed; but we have reason to learn from it a lesson of importance. Let us in time of peace prepare for war, for it cannot now be foreseen when we

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may have another conflict of arms; but such an event is possible, and we must not be found wanting when that time comes. I beg you to consider whether it be not your duty as a national body, representing the homœopathic school, to take such steps as will secure from our national government proper recognition—I mean, particularly, in the matter of the appointment of surgeons in the army and navy of the United States. Our rights must be asserted and secured.

Ladies and gentlemen, I have been called by your suffrages to this post of honor, and with it there is laid upon me important responsibilities. It will be my aim to aid you in the accomplishment of your work. The will of the majority shall be my law, and I crave your assistance and patience, that working together we may succeed in making the present the best of all sessions that have been held of the American Institute of Homœopathy.

DR. GEORGE A. HALL, of Chicago, *Vice-President*, in the chair.

DR. HALL: The members of the Institute have heard the President's address, what is your pleasure?

DR. DAKE, of Nashville: I move that it be referred to a committee of three.

Motion seconded and adopted.

THE VICE-PRESIDENT: How shall that committee be appointed?

DR. DAKE: By the Chair.

DR. EDMONDS, of St. Louis: I have in my hands a resolution, sir, which I shall now ask permission to have referred to this committee.

Resolved, That that portion of the President's address in which he deprecates personal controversies as destructive of scientific and personal progress is entitled to the cordial indorsement of the American Institute of Homœopathy.

THE VICE-PRESIDENT: I will appoint on that committee Dr. Dake, of Nashville; Dr. Dowling, of New York; and Dr. Kenyon, of Buffalo. It is also my duty to appoint an Auditing

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Committee. The Chair will appoint persons who have served upon that committee, and who are familiar with its duties.

The Auditing Committee will be Dr. D. H. Beckwith, of Cleveland, Ohio; Dr. I. T. Talbot, of Boston, Massachusetts; and Dr. H. M. Smith, of New York.

The report of the Publication Committee of 1879 is now in order. Is the Secretary ready to report.

THE SECRETARY then read the report of the ex-Secretary, R. J. McClatchey, M.D.:

PHILADELPHIA, June 12th, 1880.

To the President and Members of the American Institute of Homœopathy: I hereby beg leave to report as chairman of the Committee of Publication, that up to the present time, about fifty pages of the Proceedings of the session of 1879 have been put in type. These fifty pages embrace the general business transacted during the first three days of the session. A portion of the remainder of the Proceedings is also in type, and but little more work is required to prepare it all for the compositor. Besides these there are also ready for the printer the reports and papers of the Bureaus of Materia Medica and Provings, of Obstetrics, of Gynæcology, of Clinical Medicine, and of Psychological Medicine. The remaining reports and papers are not yet in readiness.

On the *Transactions of the World's Homœopathic Convention* nothing has been done since my last report.

Whatever may be the dissatisfaction felt by my fellow-members of the Institute at the backward state of the work of publishing the *Transactions*, no one can possibly regret it as much as I do. It has, however, been simply impossible, under the existing conditions of my physical health, for me to accomplish the work in the time allotted. The events of the past few days have thoroughly satisfied me that I cannot hope to continue my work on the *Transactions*, except at the hazard of great danger to my health and perhaps the peril of still more serious consequences. Acting under this conviction I have transferred to Dr. Joseph C. Guernsey, my colleague on the committee, all the MSS. and archives belonging to the Institute, and must ask to be relieved of all future responsibility as a member of the Committee of Publication.

R. J. MCCLATCHEY, M.D.

DR. D. H. BECKWITH: I move that the report be received and referred to a committee.

DR. ALLEN, of Michigan: I move that it be referred to a committee of three.

THE PRESIDENT: Is there any second to that resolution?

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DR. LILIENTHAL: I second that motion.

DR. ALLEN: I think that it is a shame that this matter should be in the condition that it is, and I think that it should be finally settled, and that Dr. McClatchey should be relieved.

THE SECRETARY: You will please reduce your motion to writing.

THE PRESIDENT: The motion is in reference to the report of the former Secretary.

DR. E. M. KELLOGG, of New York: I have here a brief communication from the late Provisional Secretary, Dr. Guernsey, which I would like to read to the members of the Institute. It is dated Philadelphia, June 12th, 1880: "The undersigned respectfully reports that yesterday afternoon he received from Dr. McClatchey what purports to be the manuscript relating to the World's Homœopathic Convention, held in 1876, and the manuscript of the session of this Institute in 1879. This matter he now holds waiting the Institute's pleasure as to its future disposal."

THE PRESIDENT: This is all by way of information. What shall be done with this communication?

DR. DAKE: I move that it take the same course, and be referred to the same committee.

THE PRESIDENT: The two reports will be joined in one and passed in one motion to refer.

The motion to refer the ex-Secretary's report and the communication from the Provisional Secretary was then adopted.

THE PRESIDENT: The committee will consist of Drs. H. C. Allen, J. P. Dake, and J. C. Burgher. Is the Treasurer ready to report?

DR. E. M. KELLOGG, of New York:

The Treasurer has the honor to report the cash collections for the past year as, ...	$2769 00
Balance in hand one year ago, ...	895 15
Total, ...	$3664 15

The disbursements for the past year have amounted to about $1000, a most unsatisfactory report when we consider that we have nothing as yet to show for it.

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The disbursements are as follows:

Bill of Jackson Brothers, printing,	$39 25
Bill of Secretary for mailing copies of volume of 1878,	66 00
Bill of Sherman & Co., printing,	45 00
Bill of Stenographer for the report of the last session,	284 85
Bill of Messrs. Morgan & Co., Lithographers,	97 00
Bill of Sherman & Co., miscellaneous printing,	60 50
Balance due on work of World's Convention,	112 75
New cash-book for the Treasurer,	1 75
Bills of the Bureau of Registration, Dr. Talbot,	33 39
Packing and shipping *Transactions*,	7 00
Contribution to the World's Convention, returned to Dr. D. H. Beckwith, of Ohio,	108 00
Paid to the Secretary for miscellaneous expenses, including postage, printing, trip to Philadelphia, etc.,	125 72
Treasurer's bill for postage, expressage, telegraphing, stationery, etc.,	132 65
Total,	$1113 86

I stated the disbursements would be about $1000, because this $108 which was returned, being contribution received from the State of Ohio, was not properly a disbursement.

DR. MCCLELLAND, of Pittsburg: I move that the report be accepted, and referred to the Auditing Committee.

Seconded by several.

THE PRESIDENT: You have heard the motion of Dr. McClelland.

DR. O. S. RUNNELS, of Indianapolis: There is an item of $108 returned to Ohio for some purpose, being part of the contribution to the World's Convention. I would like to ask to whom that money was returned.

DR. D. H. BECKWITH, of Ohio: I will explain it, if you please. I was appointed on the committee to solicit money for Ohio by Carroll Dunham. He made a visit to Cleveland, and stated that it was important that they should have the money. I went around among my friends and solicited $108. Dr. Kellogg wrote me three or four times that the work was in press, and would be out in three or four months, and he solicited the contribution from Ohio. I waited upon my friends and procured

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the money, and forwarded it. We have now waited four years for the *Transactions of the World's Convention*, and have not received them yet. When I was asking for some more money for our hospital, they said that they had already subscribed for the World's Homœopathic Convention, and had not received anything in return; and I wrote to Dr. Kellogg in relation to the matter, and he returned me $108. This I gave back to those who had formerly made the contributions. That is where the $108 went to.

DR. KELLOGG, of New York: I would state for the information of Dr. Runnels, that $70 of this $108 is for the subscription of seven persons at ten dollars each for the volumes of 1876.

DR. OWENS: I should like to inquire if the $10 I paid was accounted for in the $70?

DR. KELLOGG: I refer you to Dr. Beckwith.

DR. RUNNELS: Would you like this $10 refunded?

DR. OWENS: I don't wish to have the money returned. I merely asked the question as a matter of inquiry. If it was coming to me I should not refuse to receive it.

THE PRESIDENT: The question is on referring this report of the Treasurer to the Auditing Committee.

The question being on referring the report of the Treasurer it was agreed to.

THE PRESIDENT: The Auditing Committee before announced will take charge of the report of the Treasurer, and make their report. The committee consists of Dr. Beckwith, Dr. Smith, and Dr. Talbot.

DR. KELLOGG, of New York, continuing: The total contribution which I have received as Treasurer for the World's Convention of 1876 I have classified under three heads: First, the contributions by States. Voluntary contributions received from the State of New York, $915.00; Pennsylvania, $318.50; Massachusetts, $229.50; New Jersey, $184.00; Rhode Island, $105.00; Illinois, $86.00; Connecticut, $50.00; Indiana, $44.00; Wisconsin, $44.00; Maine, $43.00; Vermont, $32.00; Missouri, $28.00; Minnesota, $25.00; Tennessee, $16.00; Maryland,

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$10.00; District of Columbia, $8.00; Ohio, 7.00; Louisiana, $4.50; Georgia, $4.00; California, $2.50; Total, $2156.00.

In explanation of the smallness of the subscriptions of the State of Ohio, I would state that it was originally $45, of which $38 were refunded, thus leaving the total subscriptions by States at $2156.00.

I have also received from the sale of volumes $268.61, exclusive of $70 returned to Ohio subscribers.

I have expended on account of the World's Convention in 1876, under the direct orders of the late Carroll Dunham, for translating, printing, and electrotyping various papers, and clerical and editorial work, $1284.38. Other disbursements during 1876, $46.51. On January 6th, 1879, I paid to Sherman & Co., of Philadelphia, for work done on these volumes under the supervision of Dr. McClatchey, $1000. And also during last week a final balance of $112.75 was paid to the printers, making a total of $2443.64 for disbursements up to date.

The receipts from States and the sale of volumes amount to $2424.61, which shows that the disbursements have been $19.03 in excess of the receipts. But the Institute made an assessment of $2.50 upon its members to create a fund, because it was calculated by Dr. Dunham and other members of the Institute that the expenses of the World's Convention would probably amount to $7000, and this assessment of $2.50 was made, and has been paid to your Treasurer by 698 members, which makes a total from that source of $1745 towards the publication of these volumes. This also ought to be reckoned in. So that the disbursements, although they appear large now, and appear to swallow up the contributions for the World's Convention fund, still leave a large sum as yet unused, amounting to $1725.97, which is included in the present cash balance in the Treasury of the Institute.

Dr. Beckwith: I would like to ask where the interest of the $108 for four years has gone to.

The President: The question is out of order.

Dr. E. M. Kellogg: I would like to answer that question before the Institute, by stating that the greater part of that

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$108 was paid out on Dr. Dunham's orders before the World's Convention met.

DR. DAKE, of Nashville: I move that this supplemental report be referred to the Auditing Committee, together with the other report.

THE PRESIDENT: The motion is that this report be referred to the Auditing Committee.

DR. DAKE: This report together with the regular report of the Treasurer. If it is in order I would like now to say one word. I wish to say the honor of the Institute is at stake in receiving money from outside parties for *Transactions* which have not been published, and which they have not received. I therefore am pleased with our Treasurer because he has given us a supplemental report, and told us how much money was received for the World's Convention, and for the *Transactions*, and what has been done with the funds. I am sure it will be very gratifying to the Institute to know that these moneys have been carefully kept and not wasted, and that we shall have the full benefit of every dollar.

DR. KELLOGG: I ought to add, Mr. President, that I did not give the balance on hand at the close of my report. The balance is $2550.29.

THE PRESIDENT: The supplementary report is in order.

A MEMBER: What is this balance?

DR. KELLOGG: It is the balance on hand at date.

THE PRESIDENT: The question of the reference of this report to the Auditing Committee is now before the Institute.

The question being on the reference of the report, and supplemental report to the Auditing Committee, it was agreed to.

DR. B. W. JAMES, of Philadelphia: It is well known to the members of the Institute that last year Old England sent us a delegate who was with us through our deliberations in 1879. In 1876 she sent us several delegates. This year we have with us another delegate from Old England in the person of Dr. E. W. Berridge, of London. I think, Mr. President, as long as we have one from such a great distance, and the old country has so honored us, that we should invite him to a seat upon the

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platform, and I therefore make the motion that he take a seat upon the platform, and take part in our deliberations.

THE PRESIDENT: Ladies and gentlemen, I have the pleasure of introducing to you Dr. E. W. Berridge, of London.

DR. BERRIDGE: *Mr. President, Ladies and Gentlemen:* I can only thank you most sincerely for the honor you have done me. I have been in this country of yours now but fourteen days, and I am delighted with all I have seen around me. It is with great pleasure to me that I meet with you here.

THE PRESIDENT: The next thing in order is the report of the Board of Censors. Dr. F. R. McManus not being present, and not being in the city, Dr. Lewis Sherman is the only member of the board present, I believe.

DR. SHERMAN: I announce that I will hold any applications until this afternoon, when Dr. McManus is expected to be here.

THE PRESIDENT: In the meantime Dr. Lewis Sherman will act as chairman of the Board of Censors. The Secretary is supplied with blanks to be filled out. The other members of the Board of Censors will be appointed. Dr. Lewis Sherman, of Wisconsin, chairman; Drs. O. S. Runnels, R. F. Baker, and H. B. Van Norman will constitute the Board of Censors.

The report of the Necrologist is now in order.

DR. MCCLELLAND, of Pittsburg, Pa.: I have been requested to present the report of Dr. Paine, of New York.

SUMMARY OF THE NECROLOGICAL REPORT FOR 1880.

Intelligence of the death, since the last meeting of the Institute, of nineteen of its members, has been received by this bureau.

Among those who have thus been taken from our fellowship, four had been for several years well up on the roll of seniors, viz.: *Dr. W. S. Helmuth*, of Philadelphia, Pa.; *Dr. C. J. Hempel*, of Grand Rapids, Mich.; *Dr. Moses Dodge*, of Portland, Me.; and *Dr. E. A Munger*, of Waterville, N. Y., whose names and reputations have been long familiar not only to our society, but to the profession at large.

Dr. Helmuth, who died so recently as last April, was one of the original members and founders of the Institute, and was also one of the founders of the Hahnemann Medical College of Philadelphia, in which also he served for a number of years, at different times, as professor and as trustee. He died at the age of 79.

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Dr. Hempel, whose name has become so widely known throughout our school by the numerous and valuable writings, translations, and compilations contributed by him to the literature of homœopathy, has been for several years debarred by loss of sight and other infirmities, from the prosecution of those useful labors to which he formerly devoted so large a portion of his time and talents. He passed to his rest in September last, aged 67 years.

Drs. Dodge and *Munger* were justly held in high estimation for their professional attainments and large experience, and were honored by their younger colleagues as pioneers and standard-bearers of homœopathy in their respective districts. They were both among the early adherents of our organization, and in former years were regular attendants at its annual sessions. Dr. Munger was 66 years old.

It is with deep sorrow that the announcement is made of the decease, in November last, at the ripe age of 75 years, of the *Marquis de Nunez*, of Madrid, Spain, an honorary member of the Institute, of world-wide reputation as a learned disciple of Hahnemann, and princely promoter of homœopathy in his native country. It has been publicly stated that he bequeathed a large estate for the endowment of the St. Joseph Hospital in Madrid, of which he was the founder.

Of the other losses which the Institute has recently sustained, there are some that will be long and deeply felt by many of us who survive, with whom they have been actively associated in the work and business of the society.

The following enumeration contains the names of all the deceased members not already mentioned, who are more fully commemorated in the report, including a few whose deaths occurred previous to the last meeting, but, for want of information, had not been recorded, making nineteen in all.

Dr. Warren Freeman, of New York, died April 5th, 1880, aged 65 years. A member of 22 years' standing.

Dr. Franklin Bigelow, of Syracuse, N. Y., elected 1854, died March 12th, 1879, aged 52.

Dr. John Augustine Ward, of New York, died March, 1880, aged 50 years. He was elected in 1856.

Dr. John H. Woodbury, of Boston, Mass., late Professor of Gynæcology in the Boston University School of Medicine. He was born 1831, joined the Institute in 1859, and died at Clifton Springs, February 28th, 1880.

Dr. Michael Friese, of Harrisburg, Pa., elected in 1866, and died February 4th, 1880.

Dr. E. B. Harding, of Northampton, Mass., elected in 1867, and died April, 1877.

Dr. Lafayette Bushnell, of New York, born 1824, a member since 1870, died July 9th, 1879, aged 55.

Dr. A. H. Botsford, of Grand Rapids, Mich., died January, 1879. Was elected 1870.

Dr. Harrison V. Miller, of Syracuse, N. Y., born 1828, elected 1871, died November 26th, 1879, aged 51 years.

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Dr. James M. Cadmus, of Waverly, N. Y., elected 1871, died suddenly May 10th, 1879, aged 45.

Dr. W. H. Woodyatt, of Chicago, Ill., Professor of Diseases of Eye and Ear in the Chicago Medical College, died January 31st of this year. Elected 1873.

Dr. F. H. Bradner, of Middletown, N. Y., President of the local Board of Health, elected to the Institute 1874, and died January 31st, 1880, at the early age of 31.

Dr. George R. Knight, of Collegeville, Pa., and *Dr. L. M. Smith*, of Canton, Ohio, of whom no particulars have been received beyond the announcement of their decease.

Further information will be gladly received to the end that suitable memorials may be incorporated at least in the next report.

This may be a proper place to suggest that in all cases of death among the members of our confraternity, it would promote accuracy and fulness of statement, and greatly relieve the labors of the Necrologist, if relatives or friends of the departed would considerately forward to this committee, as early as may be, such papers and documents as will best supply the desired information.

The duty of preparing these brief memorials of our departed associates has been a labor of love for a number of years on the part of the present incumbent of the office, but he has sometimes found the obtaining of the necessary data for his purpose a matter of considerable difficulty, and often involving a large amount of correspondence.

HENRY D. PAINE,
June, 1880. Necrologist.

DR. FOOTE, of Connecticut: I move that the report be received and referred.

Agreed to.

THE PRESIDENT: The next business in order is the Bureau of Organization, Registration, and Statistics. The report of the chairman of the bureau will now be in order. Is Dr. Talbot ready to report?

DR. I. T. TALBOT, of Boston: *Mr. President, Ladies and Gentlemen*: The Bureau of Organization, Registration, and Statistics have found in their work of this year a wealth of material which could not be presented to you in detail, the report of one and another institution read at length, but they have endeavored to summarize it in such a manner as to give to the Institute, and the members present here, and to the members who will receive it if the Institute will see best to publish it in its *Transactions*, a summary of the conditions of those institutions throughout the

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length and breadth of these United States. To those who know nothing of the work, the difficulty of securing from different individuals full and accurate reports for the bureau will not be appreciated. It has been a matter of great difficulty. We have had sometimes to urge upon the members of the Institute, and upon physicians throughout the United States, and those interested in homœopathy, that this matter should be attended to, and that they should assist this bureau in completing and perfecting these statistics.

We have classified the different institutes into State societies, national societies, interstate and sectional societies, State societies and local societies; also, State societies and hospitals, dispensaries, colleges, journals, directories, and miscellaneous associations. The National Society of the American Institute of Homœopathy at present numbers about 839 members. The most complete list of homœopathic physicians, verified by reference to their names in the directories, includes about 6000 physicians in the United States. This is undoubtedly below the real number of practicing homœopathic physicians, but is the most complete and verified list we have. It would seem as though that out of that 6000 more than 839 should be members of this national association, and the bureau feels that it is within the power of the Institute itself to increase its number very largely by giving in return to every member more than he gives to the Institute. Another national association of homœopathy is the Ophthalmological and Otological Society, and is one of a special character, organized for special work, and has 40 members. It is for them to decide whether it is better to continue their work as a separate organization or as a department of this national association. There is one sectional or interstate organization, and there are several which contain members residing by their different localities in different States; but one, the Western Academy of Homœopathy, with 150 members from the Western and Northern Mississippi States, is the largest and most prominent, doing a great amount of work. There are 23 organized; 17 of these are incorporated by acts of the legislatures of their States. Of these various State societies the membership amounts to 1859. To their membership was added this last year 183; died, 28. The annual

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dues of these societies vary from $1 to $5. The meetings of these societies are all, I think, annual, some having semiannual, and others quarterly meetings. One word in regard to the localities of these State societies. With the exception of two, they are all included in the Northern States. Tennessee and Maryland I refer to. I should also say that Tennessee and Maryland, which were formerly accounted as Southern States, and now spoken of for convenience, that Maryland, Tennessee, and Missouri are the only Southern States which have State societies, and yet there, where our members have been formerly so few, they are now talking of organizing State societies.

These facts have been drawn up in tabular form for the convenience of the members of the Institute, giving the name of the society, its corporate name, the State in which it is located,—these are alphabetically arranged,—the year when it was organized, when it was incorporated, when the meetings are held, the members of the society, the address of the secretary of the society, the attendance of the members, the number of members admitted during last year, the number that died, their dues, what contributions they have made, and the list of the delegates. The number of the local societies is very much greater; 89 of these have come to the knowledge of the bureau. It is not a very easy matter to get at some of the societies, and undoubtedly many of them have been overlooked, and, if so, it will be an aid to the chairman of the bureau, and an aid to the Institute, if persons will give the names and statistics in relation to that matter when they come into the hall, as was done in the Centennial year, and the statistics will go into the census of the United States, and we are making as complete and full a show as is possible of our standing. Of these 89 societies, 63 have reported to the chairman of the bureau, and the membership of these 63 societies amounts to 1632. The influence of these local societies, bringing together physicians who will work in common, and who will feel an interest in the cause, and work intelligently for the bureau, I need not dwell upon; but one thing here I may say,—it does not require a great many men to make an active and beneficial society. If you can get in any local society, or in any State society, one active, efficient, capable, judicious man

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as secretary, one who will devote his time and energy earnestly to it, you have got a live, efficient, working society. There is one man needed to make that society a valuable auxiliary of our cause. The question of clubs,—social clubs,—7 of these have come to the knowledge of the chairman of the bureau, of which 6 have reported a membership of 100 members. They are principally partly social and partly scientific, and they do much to harmonize the unity of the members of the profession.

The hospital—and here I may say the bureau itself was astonished at the statistics which it had gathered. There are few of the physicians of the United States that realize the position which we occupy on that hospital question, and of the number of members; first judging as to the number of hospitals,—they have already stated it as below half a dozen, and yet there are in the United States 34 homœopathic hospitals. Twenty-five of those hospitals have reported to the bureau. These 25 hospitals contain 1505 beds, which have been occupied the past year by 14,913 patients, of whom 8455 were reported cured, 2864 much improved, 349 not improved, and 355, less than two and a half per cent. of the whole, died.

The aggregate value and cost of these 25 hospitals—we have reported 34; of the eight not reported I do not speak—has been $1,189,175, besides two hospitals owned by the separate States, which are not included, and one by the city of New York, the Ward's Island Hospital, New York, erected at an immense cost. These are not included. The amount of debt on all these hospitals combined is $85,000. The amount of funds invested and belonging to them is $41,206; showing that with a property costing about $1,230,000, there is a debt of only $85,000.

The local societies have been arranged in a similar manner. The State societies, for convenience of reference, and hospitals, are all arranged in a similar manner—the name of the hospital given, where located, in what town or what city and State, alphabetically arranged, when it was incorporated, when opened, the number of patients, the address of the secretary or chief executive officer, the number of beds which it contains, the number of patients last year, the number of patients cured, relieved, or died, the value of the hospital and grounds, the amount of debt and

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invested property, the sources of income, and the delegates to this Institute.

The Homœopathic Dispensaries in the United States.

Of the 29 dispensaries which have come to the knowledge of the bureau, 22 have reported. They report having treated in the last year 103,579 patients, and have given 220,803 prescriptions. Five of these are supported by hospitals, and four by colleges with which they are connected, and one by the city of New York, which is local, and one by the State; while the expenses of thirteen of these dispensaries are $9613.27, or about five and one-half cents for each prescription to the sick. Notwithstanding the amount of good accomplished by these dispensaries, very few of them have been provided with any means of support outside of the contributions of their patrons and those most interested in them; and generally the physician himself, who is most interested, has to pay the bills or get his friends to do it. And of all these dispensaries there is $27,649.52 as the combined amount of endowments that were received. On all these dispensaries there is less than $2000 debt.

Of course there is a subject which should come up for discussion, on the duties of the community to support these dispensaries and hospitals, and the necessity of our urging upon them attention to the ways and means in which it may be done. This will be a subject of great interest to the profession and to the Institute.

Colleges.

Of the eleven medical colleges, all of which have now reported to the bureau, the term of instruction in all of them is at least five months each year, while two continue six months in their teachings, one eight months, and one nine months. Six of these colleges have established a graded course, covering three full years, in two of which it is obligatory on all their graduates, and the colleges are making special efforts to increase the amount of medical instruction. In one college a four years' course has already been successfully inaugurated. The number of students for the past year has been 1192; the number of graduates this

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year, 387; the number of alumni graduated from these colleges since they were established already amounts to 4822; showing the work which these colleges have done to give success and spread to homœopathy. The various faculties aggregate 159, of whom one hundred are professors, and the remainder lecturers and instructors. The amount of property in five of these colleges is $230,000; the endowments additional, $45,000; the amount of debt, $53,000. The income of six of these colleges from various sources amounts to $50,727.

Special Schools.

There are two special schools, the ophthalmic and obstetric, with 26 students, 18 graduating last year. 182 alumni have graduated from these institutions, in which there are 14 teachers in their faculties.

Journals.

Of the journals, there are published in the United States 16 homœopathic journals. I would say of the colleges that they have been drawn off in a similar style—the name of each college, location, when incorporated, when the students were first admitted, the name and address of its executive officer, the length of each year, course of time allowed, the number of courses required before graduation, the number of students for the present year, the number of graduates for the present year, the number of its alumni, its faculty, professors, and lecturers, the estimated value of its property, the amount of endowment, the amount of debt, the amount of its income, and its delegates to the Institute.

Of the homœopathic journals, 16 are published in the United States. Four of these are quarterly journals, one is published every two months, ten of them are monthly journals, and one a semi-monthly. These have a combined circulation of 22,250 covers, a monthly issue—combined monthly issue—of all of them, or 700 pages, making a yearly issue from our school of 8400 pages of matter.

Directories.

Of the directories there are seven published in the United States; one of which is a general directory, covering the whole

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United States; six covering sectional portions of the United States; some include a single State, and others several States combined.

This, Mr. President, is, we can hardly call it a report to the Institute, but such as it is, a report of such matters as it seemed desirable to bring before the Institute at an early date, so that if the members would kindly assist in completing these statistics before they go for publication, it will greatly aid the bureau. With your leave the bureau will, at the close of the session, make a complete report, including in the report the names of the delegates accredited to this meeting, together with the names of members present; and, for that purpose, the bureau ask that you will kindly hand to the bureau the name and address of all the members who are present at this Institute, that the list may be made; also all the credentials and reports that they may bear with them.

By the President: You have heard the report of the chairman of the Bureau of Organization, Registration, and Statistics. What is your desire?

Dr. J. Edward Smith, of Ohio: If I understood the chairman's report correctly, I think there has been an omission made, not intentionally on the part of the chairman by any means, but an omission the character of which ought not to occur. To be more definite, the point I allude to is this, in referring to the use and support of the various dispensaries it was stated practically that a certain number of these received their support from hospitals, and, as I understood, from the colleges. There is an error in fact involved in that statement; and this covers up one important matter which ought to see the light. I will state that a few years ago the local lady physicians of one of our States formed an association for the purpose of establishing a ladies' dispensary. They insisted upon performing this work themselves, and asking no favors of any one, except such funds as they might collect by voluntary contribution. What I mean is they asked no assistance from the hospitals or the colleges where they were situated. They bent their energies to the task, and by dint of first-class energy, perseverance, and assiduity they made a very nice and successful matter of it. They formed what is known as a "Women's

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Dispensary," and through their aid a college, our local college in that city, has been largely benefited. I think it is a fact that ought to be known for that reason. We have very few of these lady societies in the country, and it shows the possibility of their doing first-class and valuable work, and of rendering to the cause of homœopathy valuable assistance. It is a matter for which I have great regard, and one I think ought not to be buried.

DR. LILIENTHAL, of New York: We have in New-York three dispensaries, most excellent ones, all attended by ladies, and supported by ladies, and one of them, especially, which I have in my mind now was started by a lady as a Providence dispensary, —meaning that Providence will take care of it,—and every patient who comes there pays ten cents or a quarter for attendance, or whatever they are willing to pay, and that supports the dispensary. There are two others, one on 41st Street, supported by ladies. And, as Dr. Smith says, they do not ask any favors from anybody.

DR. SMITH, of Ohio: I think the dispensary to which I have referred discounts that of our friend.

THE PRESIDENT: It is rather the opinion of the Chair that the gentlemen are out of order. They are now entering into a little matter between themselves, and I shall have to cut it short. The report is before you; what will you do with it?

DR. TALBOT, of Boston: I wish to correct that matter. I hope I don't give the impression which I judge from Professor Smith's remarks was given, that certain of these dispensaries were supported by the hospitals and others by colleges. I had no intention of creating that impression. The remark I made is not intended to carry that idea. I hope I put it in the way in which it should be understood. There are twenty-nine dispensaries, twenty-two being reported. These are supported by the hospitals with which they are connected. It is the out-patient dispensary department of the hospital, and the expenses are included in the hospital expenses, which are not given separately. Four of them are supported by the colleges with which they are connected, the rest are supported in various ways. But I am very glad that Professor Smith has brought the subject up, for it is one of the most interesting that the bureau have met in the whole

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of their investigation,—the methods by which these dispensaries are supported. One poor girl lying sick on her back hears of a family that are wanting homœopathic treatment, and are unwilling to accept it from a physician gratuitously, and are unable to pay for it. And through this poor sick girl others are interested, and her friends are told, and in this way a dispensary is established, which last year has contributed to about 5000 out-patients, and has actually put up a building for a hospital, and within the last ten days secured from a man with means behind him, but who keeps them there as a rule, but by her earnestness, her directness of purpose and continuance, has secured $15,000 from that man to establish that hospital. And not only did the work of establishing a hospital, but interested others to give $3000, $2000, and $1000, and $500, and smaller sums, until a beautiful lot and fine building have been secured for the hospital, which is doing excellent work. My friend Dr. Smith knows very well what hospital work is. But when we have gone to work earnestly they see the result of their work. You know that a man in Pittsburg has come forward and offered $50,000 if they will raise an amount equal to it. When work is commenced of this kind, it is surprising what an advance will be made. One man will give $5000, another $10,000, and others smaller sums. If the public are only roused, and if the physicians are only earnest and work continuously, much can be done. Much has been done in Pittsburg and Philadelphia, and in Boston. In those places money is waiting to build our hospitals, and in every city where there is an earnest working body of physicians a hospital and a dispensary can be established without any doubt; and the expense which Dr. Smith has given us, the expense of one dispensary,—and that is only one of a very large number which pervades throughout the country,—will be very slight. And if the meeting of this Institute can do something to encourage our body every year to add to these statistics, that we may see the growth of homœopathy, that we may see it in its magnitude extend over the country, we shall have an encouragement that will be worth all the trouble and all the expense that the American Institute incurs in its yearly meeting.

THE PRESIDENT: What will you do with the report?

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DR. HALL, of Chicago: I move that the report be received, and the recommendations adopted.

DR. MCCLELLAND, of Pittsburg: I second the motion.

Agreed to.

THE PRESIDENT: If there is no other business we will proceed to the reading of the report of the Bureau of Anatomy and Physiology.

Before that report is made Dr. Sherman, of the Board of Censors, wishes to make a report.

Dr. Sherman then presented a partial report. (See complete report of the Board of Censors.)

THE PRESIDENT: You have heard the report of the Board of Censors. What will you do with it?

DR. SPALDING: I would like to make one suggestion. To me these people are all strangers. If any one is proposed as a member of this honorable association he should be known to the person who proposes him. Great care should be taken in this respect. It is a disgrace to this body to have members elected of this honorable association when this precaution is not observed. The names of applicants should be scrutiuized by every member of the society. The members who are recommended by the Board of Censors should be carefully watched in regard to the character of the gentlemen whose names are presented. If this is done it will save a great deal of trouble to this society, and will save disgrace to us. We all know this has not been done in the past, and we have cause to regret it. I think that we ought to know the names presented here to be immediately voted upon before the vote is taken. I think, for the safety and good of the society, that we ought to protect ourselves in some such way. It is known to us that a great many names are certified to by physicians as a matter of favor, and not because they are personally acquainted with the applicants. This ought not to be so, but without doubt it is so. We know that it has been done at this session. I would suggest that those names that are presented at this session be vouched for by persons who are personally acquainted with the applicants. They should be acquainted with their residence, their moral character. Too much

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care cannot be taken in this respect; the greatest vigilance should be exercised.

THE PRESIDENT: The motion has been made to lay the report temporarily upon the table.

DR. FOOTE: I second that motion.

DR. DAKE, of Nashville: The motion is not debatable, but is it in order to make a remark? We have a by-law in reference to this matter of election, and governing it. The by-law provides that when the Board of Censors recommend members here for election to membership, that we should proceed to elect them. We have always done so, and there has never been a recommendation of this board that has been laid on the table.

THE PRESIDENT: The Chair thinks that the gentleman is not in order.

DR. DAKE: I am discussing a point of order.

THE PRESIDENT: State your point of order.

DR. DAKE: I was just speaking of a by-law regulating this matter.

THE PRESIDENT: This motion is to lay on the table, and is the only question which is in order before us, and must be acted upon without debate.

The motion to lay on the table was negatived.

THE PRESIDENT: The question is upon the motion of the chairman of the Board of Censors that the names read by him be admitted as members of the Institute.

Motion agreed to.

THE PRESIDENT Are you now prepared for the Bureau of Anatomy and Physiology?

DR. H. B. VAN NORMAN, of Cleveland, Ohio, Chairman: Mr. President, I have but a brief report. There are only two members of the bureau present, and but one paper to read.

Dr. Spalding will read his paper on the Sphincter Tertius. I have a paper incomplete on Life, which I will present only by title.*

Dr. Henry E. Spalding, of Hingham, Mass, then read his paper on the Sphincter Tertius.

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* Paper not received.—GENERAL SECRETARY.

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THE PRESIDENT: That closes the report of the Bureau of Anatomy and Physiology. What will you do with the report of the bureau?

DR. B. W. JAMES: I move that it be referred to the Committee on Publication.

Agreed to. (See Appendix to Bureau, Discussion.)

THE PRESIDENT: The bureau is now closed, and the Chair will appoint William Von Gottschalk, M.D., Providence, R. I., chairman of the bureau. The next bureau is the Bureau of Psychological Medicine.

DR. BROWN, of Binghamton: In the absence of Dr. Talcott, who was prevented from coming to this meeting, I will present his report and papers. The bureau has four papers to present for consideration. The first paper is by Dr. Talcott on Phimosis in its Relations to Insanity, which according to the rule adopted years ago, when I was chairman of the bureau, will be read by title and referred.

The next paper is by Dr. Lilienthal, of New York. The title of the paper is The Transitory Fury.

The doctor then read his paper.

DR. BROWN: The next paper in order is entitled The Prevention and Cause of Intemperance, by Dr. George F. Foote, of Connecticut.

(Dr. Foote then read his paper.)

DR. BROWN: The fourth and last paper is one of my own production; it is very brief, and I shall be pleased to read it with what I have here given you. This is the result of my own experience and labor. The title of the paper is Morbid Vision.

The paper was then read.

DR. DAKE: I move that the report of the bureau be received and the papers be referred to the Publication Committee.

THE PRESIDENT: Why not have the paper of Dr. Talcott read.

DR. DAKE: It is the custom to read by title the papers presented by absent members.

THE PRESIDENT: Does the chairman of the bureau ask the privilege of the Institute to have the paper read?

DR. BROWN: I think it of some interest; it will take but a

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little time to read it. Dr. Talcott is a hard worker; I mean in his specialty, in his bureau. I do not want to stand in the way of his paper being read. It can be read if the members wish it.

DR. BECKWITH: Let us have it read.

Dr. Hall, Vice-President, at this point took the chair.

THE VICE-PRESIDENT: Do you make a motion?

DR. BECKWITH: I move that the paper of Dr. Talcott be read.

The question being on the motion of Dr. Beckwith to read the paper of Dr. Talcott, it was agreed to.

Dr. McClelland, of Pittsburg, then read the paper of Dr. Talcott.

DR. MCCLELLAND: The title of the paper is Phimosis in its Relations to Insanity.

DR. DAKE, of Nashville, Tenn.: I renew my motion to refer the papers of this bureau.

THE VICE-PRESIDENT: Are you ready for the motion to refer Dr. Talcott's paper to the committee.

DR. DAKE: The Committee of Publication.

DR. LILIENTHAL, of New York: You should remember before referring the paper of Dr. Talcott to the Committee of Publication that Dr. Talcott's paper is printed. I have mine printed also for the purpose of bringing up Article VII, Section 9. I wish to make a motion in relation to that before the society. You will all remember that the article in the section to which I refer lays down the law that no paper shall be published in the *Transactions* that has been previously published. Now my paper is published, and Dr. Talcott's has been previously published.

DR. DAKE: I withdraw my motion in regard to the paper read by Dr. McClelland, and also in reference to the one read by Dr. Lilienthal.

DR. BROWN: Is discussion in order.

DR. LILIENTHAL: We now bring it before the society on account of the fact that the papers have been kept back for three or four years, when the interest in the papers has ceased to be felt. My desire is to bring this matter before the society in order to determine whether these papers can be published in the *Transactions* or not.

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DR. MCCLELLAND, of Pittsburg: The By-Laws say no.

THE VICE-PRESIDENT: As it now stands no such paper would be admitted, of course.

DR. LILIENTHAL: Certainly that is the law at present.

THE VICE-PRESIDENT: The papers are now ready for discussion, taken in the order in which they were presented. Which was the first?

DR. LILIENTHAL: My paper was the first. Dr. Hofmann told me that Dr. Seip, of Pittsburg, had a case of transitory fury.

DR. HOFMANN: I don't know sufficient of the case to announce it perfectly. I only understood that the patient had inhaled laughing gas for the purpose of having a tooth extracted, and that several hours after he commenced acting strangely and getting into such a furious state that it was almost impossible to control him. It was astonishing what strength he exerted. It was all that four or six men could do to hold him down. After getting the patient quiet by the administration of Belladonna—that being the indicated remedy—he commenced to sleep and slept for twelve hours. On awaking he was perfectly sound and rational.

THE VICE-PRESIDENT: Are there any further remarks on Dr. Lilienthal's paper.

A MEMBER: How was the man on waking up?

DR. HOFMANN: Perfectly sound and perfectly well. He did not know anything of his former condition.

DR. LILIENTHAL: Still that does not apply to transitory fury, because in this case laughing gas was administered. That might account for the paroxysm of transitory fury. That would produce hyperæmia of the brain. The question which is brought to our minds is as to the cause of transitory fury. This might be answered in this case by the fact that the patient had taken laughing gas, and it was followed by such a congestion of the brain that the patient had a paroxysm, followed by sound sleep.

THE VICE-PRESIDENT: Each speaker is allowed to speak only once, except by consent of the Convention.

DR. MCCLELLAND: Where was your paper published, Dr. Lilienthal?

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DR. LILIENTHAL: My paper was published in the *North American.* I am sorry that Dr. Smith is not here from Cleveland. He tells me that he has a paper three years old, and he has not seen it in the *Transactions* yet. That is the trouble with our By-Laws, but we want to try and overcome it by having Article VII, Section 9, modified.

DR. BROWN: I think that would come under the head of miscellaneous business. I think it ought not to come in here to interrupt the discussion of this paper.

THE VICE-PRESIDENT: If there are no remarks, Dr. Lilienthal's paper will be laid on the table.

A MEMBER: What has become of Dr. Foote's paper?

THE VICE-PRESIDENT: If there are no objections that will be referred to the Committee on Publication. The next paper is entitled Morbid Vision, by Dr. Brown. Are there any remarks to be made on Dr. Brown's paper. That is now open for discussion. If there are no remarks the papers will be referred to the Publication Committee.

THE VICE-PRESIDENT: If there is no objection the paper will be so referred. The next paper is by Dr. Talcott on Phimosis. That paper is now open for discussion. Have you any remarks to make on that most interesting paper.

DR. MCCLELLAND, of Pittsburg: I can only say I indorse the position taken by Dr. Talcott, not an original one, of course; but that very many conditions, I think, will be admitted are due to this cause. When these irritations and errors in digestion, and errors in nutrition, are taken into account, and many other diseases in childhood and in adult life are considered, I think it will be found that they are due to this separate cause of phimosis or partial phimosis. I have always been in the habit of seeking out those remote causes where it is possible, and where I can find no other efficient cause or remedy, and when this physical defect has been remedied the result has been an improvement of the patient and final recovery.

DR. BROWN, of Binghamton: *Mr. President:* If it is in order, I would like to relate a fact about the paper I have read and make my comparison.

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THE VICE-PRESIDENT: That paper has been referred and disposed of.

DR. BROWN: Then I rise and ask permission to do so.

THE VICE-PRESIDENT: Will you please wait until we get through with Dr. Talcott's paper.

DR. OWENS: I would like to say in reference to the first case mentioned in Dr. Talcott's paper, I do not think it is a proper case to give under the head of mental aberration. There is no form of phimosis in the ancestors themselves who were deranged or maniacal, as I understand the doctor's paper. That is the only paper which has any description which would lead us to form any conclusion in regard to the merits of the case. We all know that the habit of masturbation is one of the most pernicious and degrading of all habits, and tends to demoralize a man and discourage him, and it produces this group of conditions described in this paper, and perhaps more serious results more generally than any other one cause, whether phimosis exists or not. Now in this connection there are hundreds of cases of phimosis existing in which there is no such thing as any aberration. I wish the gentleman would consider that matter a moment. There are hundreds of cases in which there are no mental aberrations whatever, and where there is phimosis, and where there is a small opening to the prepuce, the opening not being larger than simply to furnish an outlet for a small stream of urine. I operated upon a case of that kind within three months. It was a young man who was a clerk; a very intellectual young man at the Cincinnati bar. I also operated on another young man who was very clear-headed. I merely wish to set these off against those which have been reported. I think that there will be an offset sufficient to show that the rule does not always hold good. This matter should have and deserves our careful consideration, and I hope that we will not adopt this thing *ad captandum* without going more into the merits of the cause. Where I have noticed this condition I have found that it arose from some other cause. I hope this matter will be considered more fully in this connection. I think our information should be well extended by the members; I propose to investigate these matters for myself.

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DR. WOOD, of Omaha: I would concur in these remarks in regard to this matter of phimosis—congenital phimosis. I had under my charge a young man upon whom I operated not less than a year ago, who is 28 years old. His mind, I think, is perfectly clear and has always been so. In his case the phimosis produced no other disease. Still his mind was clear notwithstanding that he had a loss of semen as often as once a week and sometimes oftener. I performed the operation upon him. It benefited the nocturnal emissions to a great extent. I think we should take the cases cited here with a great deal of allowance. I do not think it gives us positive proof that phimosis produces in all cases a condition of the kind which has been mentioned.

THE VICE-PRESIDENT: We will close the debate if there are no more remarks.

DR. MCCLELLAND: I wish to say a word or two on the subject. I think there has been a misapprehension in regard to the paper.

THE VICE-PRESIDENT: If you rise to make an explanation you are in order.

DR. MCCLELLAND: I think that Dr. Talcott's paper does not claim that every case arising from phimosis is a case of insanity. He gives that as a cause of insanity in some cases. He gives a case in which insanity disappears when the phimosis was removed. There may be cases of enuresis, and hip and joint disease, and conditions of that kind which may produce influences and results not due to phimosis, or that do not result in insanity. Phimosis may exist without anything apparent. So the paper does not claim that phimosis is always a cause of insanity.

THE VICE-PRESIDENT: The hour of adjournment has now arrived.

On motion adjourned.

EVENING SESSION.

President Wilson in the chair.

THE PRESIDENT: The Institute will now come to order. The Secretary informs the Chair that the report of the delegates from the State and county medical societies and clubs was not

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taken up before we last adjourned. If it is the will of the Institute that will be the next order of business. We are now ready for the report. There will be an opportunity for any such who are present as delegates from county and State medical societies and clubs to report. They will be given five minutes each to speak. We would be glad to have reports from any of those societies. It is quite in order. Any one can take the floor now; the order of exercises will be kept open for a few minutes.

DR. FARNSWORTH, of Massachusetts: I am one of the delegates to this Institute, but I have no special report.

DR. TAYLOR, of Indiana: I am not aware whether any other delegate has made a report from the State of Indiana, but in the absence of such knowledge, and in the contemplation of the fact that the Hoosier State is an important territory, I deem it within my province, sir, to make a brief report for it. I would say that the Indiana Homœopathic Society held its last session on May 25th and 26th, and that for the first time in the history of organized homœopathy we have agreed upon a plan of action for the purpose of placing homœopathy on as good a ground and footing as any other society in the State of Indiana, and as good a footing as is held by any other medical school, and that we have thought it best from the deliberations, before the meeting and during the meeting, to do this by congressional district organization. By organized sub-legislation, that is, having legislative sub-committees for each district, for the purpose of preparing recommendations for the legislature and perfecting other such organizations as is deemed best by the central committee, in order to bring before the State of Indiana and their representatives the question whether homœopaths were citizens entitled to the rights and privileges of other citizens of Indiana. We have determined finally to make a special stand upon that ground and to demand our rights, not as practitioners of any peculiar system of therapeutics, but as citizens of the State of Indiana, who pay taxes and who are entitled to rights in the State by reason of their rights as citizens. They have found out by thorough and repeated examination that there are in the State of Indiana about 200 homœopathic physicians, and that they have

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a following of 120,000 citizens of the State of Indiana, taxpayers of Indiana, who own about $30,000,000 worth of property, and pay taxes on it. That is the object of our movement, to know whether we, as homœopaths, have a right to stand upon that ground as American citizens, upon the rule that there should be no taxation without representation. I say that for this purpose we have adopted a plan for the purpose of establishing our rights as citizens of Indiana and determining this fact, and we shall never rest until we have gained our point.

Dr. Bowen, of Indiana: I wish to state that I come here as a delegate from the Indiana Society of Homœopathy, that we have now 100 members in our State society; at our last session we had 60 members present. That was the first time we got so many together, and I think that the efforts that were put forth at our last session will result in getting 75 to attend our next meeting. As our friend Dr. Taylor says we are going to bring homœopathy up in Indiana, and make Indiana equal to any of its neighboring States.

Dr. Peck, of Rhode Island: A few facts I may be allowed to mention which will present to you the status of homœopathy in our State. This can best be done by presenting to you the figures. We have 80 avowed homœopaths, 35 members of the State society. The surgeon-general of the State was re-elected by the legislature for a term of five years, without any opposition or voice of dissent from any part of the house whatsoever. He had previously held the office for a term of five years, having until that time been elected by a majority of the votes over the allopathic competitor. In the militia of the State the second brigade surgeon of the cavalry battalion, and the surgeon of the infantry battalion are homœopaths. So long as there was a cavalry battalion the surgeon was also a homœopath, but upon the dismounting of one company the surgeon was of course mustered out. The State Board of Health was organized and one homœopath was placed upon it, an avowed one, but not a member of our State society. Last year he was re-appointed for a term of seven years. This year another homœopath was appointed to fill the vacancy occasioned by the expiration of the term of service of the allopathic physician. This one

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is a member of our society. Thus we have two of the physicians, besides one lay member, who are homœopaths. This is a strong representation for our cause. We have every right to feel proud that we are thus represented.

Dr. Everett, of Colorado: It is my privilege to represent the newest State in the Union, the Centennial State. A State which, although it is the newest in the Union, is an important empire in itself; a State that is larger than New England and New York, and nearly as large as New England, New York, and Georgia; larger than the four Middle States; a State that contains 105,000 square miles. Colorado is a new State. It is the Centennial State. It is the newest State in the Union, but it is the State in which homœopathy is well represented. In the State are 50 homœopathic physicians. A State society was organized within the past year. This State is in its infancy, but we have a large homœopathic element there. The people that come to Colorado are mostly from the East and Middle States, and they come there bringing their homœopathic feelings with them, so that Colorado has the privilege of being represented in this Institute to-day. I am a delegate from the Denver Homœopathic Academy of Medicine, and it is my pleasure to tell you of the progress and development of homœopathy in this new State. Beneath the shadow of the Rocky Mountains, along at its base, we have established homœopathy, and it is being represented by a very large and fine class of men, and I am glad to say that we are respected there. In the city of Denver we have one of our physicians on the Board of Health, so that in Colorado homœopathy is prospering. (Applause.)

Dr. Dowling, of New York city, N. Y.: I wish to say that I was a delegate from the State Medical Society of New York, and I suppose that as we have heard such a glowing report from the West, that it will be proper to hear a few words in regard to the homœopathy of the East. It is hardly necessary to say anything in regard to the meeting of the State Medical Society. We have an annual session which convenes on the 15th of February in each year. We have also a semiannual meeting which meets at various places through the State. These meetings are largely attended, and our Transactions, as you know, are pub-

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lished by the State. With regard to the advances which homœopathy has made in New York, and in regard to the establishment of public institutions, perhaps most of you are familiar with the facts, and know of the large hospital which is under our care on Ward's Island, capable of accommodating 800 patients; it is supported by the city of New York. You know that we have a Hahnemannian hospital founded some years since, and you know of the various efforts made by its friends, and at last resulting, as you know, in the terrible disaster and loss of life, but, notwithstanding this disaster, it was financially a grand success. There was realized from the fair between forty and fifty thousand dollars in cash, which is to be devoted entirely to the establishment of free beds in this hospital. You are all aware of the fact that we have in the State of New York a large insane asylum, supported entirely by the State of New York, founded, as most of you know, by our dear friend Dr. Foote, who is present with us this evening. That institution supported by the State has 200 inmates, and the percentage of recoveries in the New York State Asylum is larger than that of any insane asylum in the United States. We have statistics which prove that, and I wish to say in behalf of Superintendent Talcott that, during his administration, not one single dose of Opium has been given, or a single dose of Chloral, nor a hypnotic of any kind. None of these things have been administered to any patient in the institution, but, notwithstanding this, it is with great pleasure that our records present the largest percentage of recoveries, greater than that of any other insane asylum in the United States. This insane asylum is under the care of homœopathic physicians entirely. As you are aware, the recently elected Governor appointed a homœopathic physician, Dr. Watson, whose name is familiar to you all, as Surgeon-General of the State of New York. We have many Brigade Surgeons who are homœopathic physicians. One of the State prisons is cared for by homœopathic physicians, and I think I am perfectly safe in saying that at least one-half of the State of New York is owned by the patrons of homœopathy. I have nothing further to say in regard to this, but I think New York is pretty well governed.

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DR. T. S. VERDI, Washington, D. C.: I would merely say that Dr. Delevàn was lately appointed as Commissioner of the State of New York.

DR. ALLEN, Michigan: As a delegate of the University Hospital, Ann Arbor, Michigan, I wish to report that we have a hospital containing 25 beds. This hospital has been built by the State, and furnished by the State, since the last meeting of the American Institute. It is filled. The hospital on the other side of the Campus is held, guarded, and kept by the allopathic school. Patients come into our hospital that have been treated on the other side of the Campus, and declared incurable, and we have cured them and sent them home. We are filled with clinics at the University. The University clinic is continually filled, very much to our surprise, while the clinics on the other side of the Campus are oftentimes barely attended; the result has been that the adherents of our school are increasing, and our students are jubilant, not only standing on the defensive, but they are also on the aggressive, so that we have this last year received as students into the University a number who matriculated on the other side. Also a very few years ago a boast was made by some members of the profession of the other school that they would give us just three years, and they would strangle homœopathy out of the University of Michigan. They have given us five years, and they are strangling us into the University, so much so, that every few years we are given new privileges.

DR. DAKE, of Nashville, Tenn.: I suppose that it is proper to say something from the South. We have heard from the East, and we have heard from the West. I am a delegate representing the Homœopathic State Society of Tennessee. I would say that we have passed through peculiar trials by reason of the yellow fever. In regard to the epidemic of 1878 you are well informed. In regard to the epidemic, scarcely an epidemic, of 1879, which visited the city of Memphis, I wish to say a word. One of our physicians there was appointed by the Howards as one of their attendants upon the yellow fever cases in the city of Memphis, during the prevalence of the yellow fever. Everything was in confusion. The practice of the physicians was disturbed. Their patients were scattered and gone; those remain-

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ing were looked after and provided for professionally by the Howards. Dr. S. J. Quimby was the physician of our school to whom I refer. I spent a day in the city of Memphis since leaving my home, and had the pleasure of looking over his record of cases, and I am pleased to say that he showed a less rate of mortality than any other physician employed by the Howards—those who were using the old-school remedies. His success attracted envy and opposition. Efforts were made on the part of some of the less liberal men of the old school to have him removed from the employ of the Howards. But his success answered their objections so completely that the Howards retained him, and he went through the epidemic with great credit to himself and to homœopathy. Our State society is growing a great deal. There are plenty of good men in the cities and towns of the State. The growth of homœopathy is quite steady and strong.

Dr. Edmonds, St. Louis: In conjunction, ladies and gentlemen, with my distinguished confrere, Dr. Wallace, of St. Louis, I have the honor of holding credentials from our city to represent the medical education of our State. It is known to most of you, doubtless, who are members of this convention, that we have for a long time been engaged in efforts there in behalf of organized medical education, and that the whole subject is gone through with. We have at last organized a plan by which we think our hopes will be accomplished. We have commenced what we hope will be a new development in the way of organization. We have what we have styled a College of Homœopathic Physicians and Surgeons. It gives me great pleasure to say that we have initiated this movement and formed this organization with strong hope and prospect that we shall be able, through the liberality of our public-minded citizens, the wealthy citizens and friends who are influential in that State, to raise a large sum of money, and get an eligible piece of ground, and build a most eligible and well-adapted house for collegiate purposes. We have not yet raised the money, but we have such promises and such indications as fully authorize us in saying that the prospect is most encouraging. We are starting out with the hope and prospect of a bright success in the cause of medical education in our State.

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DR. OWENS, Ohio: I was appointed by the State Society to represent that society in the American Institute of Homœopathy. Several other gentlemen, whose names I handed to the chairman of the Committee on Registration, Organization, and Statistics, were also appointed. I was authorized to say for them that we have a very active and live society. We had a very interesting meeting in Cincinnati of six days. In fact it was quite a success. We had quite a lively time indeed, and good feeling all around, and as large an attendance as we have had for several years. I am also authorized to represent the Cincinnati Homœopathic Free Dispensary, which is established in Cincinnati, and to say, in behalf of the papers I have presented and handed to the chairman of the Bureau of Registration, that we have been very active there during the last year. About 5000 patients have been prescribed for, and some 15,000 prescriptions given during the year. Also that there have been a large number of surgical operations performed. I cannot give you in detail all of the operations; that will be given hereafter. There is another society for which I beg leave to report, although I am not authorized to do so. It is the Women and Children's Dispensary. This is free. It was organized by two young lady physicians on the 11th of June one year ago. I attended their anniversary on the 11th of this month. They report 794 patients treated, and over 6000 prescriptions given. The expenses incurred in that way were just $120. All donated by the friends of the cause.

DR. DAKE: I move that the reports be received and the order of business closed.

Agreed to.

THE PRESIDENT: We will now proceed to the next order of business, which is the report of the Bureau of General Sanitary Science, Climatology, and Hygiene.

BUSHROD W. JAMES, M.D., Philadelphia, chairman: The subject which this bureau has selected for discussion at this meeting is Quarantine. The subject was divided up early in the session and the members were appointed to report, and you have the result on the circular. The different branches into which it was divided, and the different members of the bureau that were to prepare papers, you have before you. I have received the following papers:

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Location, by Louis A. Falligant, M.D., Savannah, Ga.

Disinfection of People, Cargo, and Baggage in Quarantine, by M. S. Briry, M.D., Bath, Me.

A paper on the Cordon Sanitaire, by R. E. Caruthers, M.D., Allegheny City, Pa.; also a paper by Dr. D. H. Beckwith, the title I have not written down here. A paper on National Quarantine, including that of the Sea-coast, by George M. Ockford, of Burlington, Vt.

I will state, Mr. President, that I was not the appointed chairman last year. Dr. Wright, of Buffalo, was appointed, but some two or three months after his appointment I received a note that he had resigned from the bureau, and he asked me to take charge of it. I wrote to the Secretary of the society stating the facts, and asking whether it was proper for me to be appointed. In due course of time I received a communication from the Secretary stating that I was appointed chairman. Dr. Wright said at the time that he was going to Europe, and he would be away over a year; afterwards he changed his mind about going, but did not change his mind in regard to the chairmanship. Therefore I report this bureau in this manner. Dr. Beckwith will read his paper first.

D. H. Beckwith, M.D., Cleveland, O.: I am very sorry that our chairman of this bureau was changed. Dr. James, the chairman, has been insane on the subject of quarantine for the last year, and gave us about nine subjects to write papers on. As he read them over you could see what a fine opportunity we all have to write, of course he taking the best, as he ought to. My subject is Quarantine for Refugees Exposed to an Epidemic of any kind, by River, Railroad or Wagonway.

Dr. Beckwith then read his paper.

Dr. James: I plead guilty to the charge of being insane on the subject of quarantine. There is only one remedy, and that is to cure me, and I am very glad that Dr. Beckwith has attempted to cure me along with the other members of the bureau. I selected ten subjects hoping to get one or two good papers. I have succeeded in getting five papers. I was glad to get that many. I have replied to seven or eight communications during the year, keeping the members posted as to the importance of

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the subject. There are two or three papers here that I will refer to by title. There are others that will be read. There is one by Dr. R. E. Caruthers, of Allegheny City, on the Cordon Sanitaire. I might, however, refer to a point or two which he makes. He refers to the fact that the cordon sanitaire was a military measure instituted in the East during the prevalence of the plague, and he says the advantage of making use of the army for this purpose lies in the fact that it is always available at short notice, and is celebrated for its discipline, and being without local bias or prejudice. The orders given to it will be faithfully and carefully carried out, and in comparison with the other forms the cordon sanitaire is preferred. I will refer to another paper by Dr. M. S. Briry, on the subject of the Disinfection of People, Cargo, and Baggage in Quarantine. The paper by George M. Ockford on National Quarantine, including that of the Sea-coast, is quite a lengthy paper, but it is well worthy of perusal. With these remarks I would refer that paper. I have one paper from Dr. L. A. Falligant, of Savannah, Ga., on the subject of Sanitation and the Location of Quarantine Stations.

Dr. James read the paper of Dr. Falligant.

Dr. James: I will close my report by reading my paper on the subject of International Quarantine.

The President: You have now heard all the papers of the Bureau of General Sanitary Science, Climatology, and Hygiene. The papers have been received and are now open for discussion.

(See Appendix to bureau.)

The President: The Chair will announce that the time for adjournment has now arrived. What will you do with this bureau; will you let it lie open?

Dr. Dake: I move that we continue this session and finish this subject before we adjourn.

The question being on the motion of Dr. Dake, it was not agreed to.

Dr. B. W. James, of Philadelphia: There is one thing which is self-evident to me. It seems to me that the subject ought to be thoroughly discussed. I think we ought to have time allowed for the discussion. I, for one, would like to see the sub-

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ject thoroughly discussed. If we have a little time in the morning I think it ought to be taken up.

On motion the bureau was closed.

THE PRESIDENT: I would like to announce the Committee on the Report of the Chairman of the Committee of Publication —Dr. McClatchey's report. The committee will be as follows: Dr. H. C. Allen, Dr. J. P. Dake, and Dr. J. C. Burgher.

I would also call the attention of the Convention to the fact that the report of the Necrologist was received and no provision made for a subsequent report. It is a committee that has to be elected every year. If you have any wish to have any committee appointed it will be necessary to have the appointment made this evening.

THE PRESIDENT: The chairman of the Bureau of General Sanitary Science, Climatology, and Hygiene for the coming year will be Dr. D. H. Beckwith, Cleveland, Ohio.

The time for adjournment has arrived.

DR. JAMES, Philadelphia: I want to offer a resolution, but I will reserve it for to-morrow.

THE CHAIR: The bureau has been closed by vote. If there is no objection by the members the Chair is willing that you should offer anything.

DR. JAMES: Have you declared the Institute adjourned?

THE PRESIDENT: I have not declared the motion as yet.

DR. JAMES: My resolution is as follows:

Resolved, That this Institute appoint delegates to present the views of this national body to the National Convention called by the President of the United States, and if delegates are admitted to its proceedings, our delegates be supplied with credentials to present to that body, and thereupon ask admittance and take part in the proceedings of the International Conference to be held in Washington. The day has not been fixed. It is passed by Congress, but the President has not fixed a time.

The resolution was seconded by several.

THE PRESIDENT: You have heard the resolution; it has been seconded. Are you ready for the question?

DR. T. S. VERDI, Washington, D. C.: I would ask Dr. James if he has read the law which was passed in Congress and

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knows how it is worded, and whether this is formed according to that law?

DR. B. W. JAMES: I have only made it in such a way in case there is such a conference. I have only taken the account in the newspapers.

DR. T. S. VERDI, Washington: It is not fresh in my mind, but I was under the impression that it was the National Board of Health and the agents of foreign governments. I am not certain of that. You have just called my attention to this fact. This matter should be understood before the resolution is adopted. I would be in favor of it.

DR. JAMES: My understanding of it has been gained from the newspaper account. I understand that Congress has authorized the President to call such a conference. I do not know if the terms were fully defined. They were not in the account that I read. If there is to be such a conference we should take cognizance of it, by the appointment of a commission from this body. It will not be out of place for us to be represented on the floor of that body. This society ought to be represented there. If it does not amount to anything it will do no harm.

The question being on the resolution of Dr. James, it was agreed to.

DR. DAKE, Nashville, Tenn.: I offer the following resolution:

Resolved, That the President of this Institute appoint two delegates to represent this Institute at the next meeting of the Public Health Association.

Seconded and adopted.

THE PRESIDENT: I will appoint as delegates Dr. J. P. Dake, Nashville, Tenn., and Dr. W. H. Holcombe, New Orleans, La.

On motion the Institute adjourned.

SECOND DAY.

MORNING SESSION.

THE PRESIDENT: The first thing in order this morning is the reports and papers of the Committee on the Law of Cure, Thomas Moore, M.D., Philadelphia, chairman. Is there any report from that committee?

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THE SECRETARY: There is no report, Mr. President, as far as the Secretary is advised.

THE PRESIDENT: The order then will be passed. The first thing will be the report of the Committee on the Clinical Thermometry of Puerperal Diseases, Henry N. Guernsey, M.D., Philadelphia, chairman.

THE SECRETARY: There is no report.

THE PRESIDENT: We will proceed with the regular business. The reports of the homœopathic medical colleges in the United States will be read by the General Secretary.

THE SECRETARY:

MR. PRESIDENT AND GENTLEMEN: The report of the Homœopathic Medical Department of the State University of Iowa, Iowa City.—The session of the college opened October 1st, 1879, and closed March 2d, 1880. The whole number of matriculants present during the session was 47; the number of didactic lectures, 416; the number of clinical lectures, 72; the number of clinical cases, 432; the number of graduates, 9.

The Pulte Medical College of Cincinnati, Ohio.—The session of the college opened October 1st, 1879, and closed March 4th, 1880. The whole number of matriculants present during the session was 86; the number of didactic lectures, 536; the number of clinical lectures, 446; the number of clinical cases, about 1500; the number of graduates, 22.

The New York College and Hospital for Women.—The session of this college commenced October 1st, 1879, and closed April 1st, 1880. It was followed by a six weeks' summer course. The whole number of matriculants present during the session was 34; the number of lectures—didactic—over 600. The clinical lectures, daily, were held at the dispensary and hospital. Graduates, 8. A three years' full course is obligatory on all students.

Report of the Hahnemann Medical College and Hospital of Chicago.—The session of the college opened October 1st, 1879, and closed February 26th, 1880. The whole number of matriculants present during the winter session was 205; spring session, about 50. The number of didactic lectures, 540; the number of clinical lectures, 168; the number of graduates, 87; the course of study, three years, discretionary.

Boston University School of Medicine.—The session of the college opened October 6th, 1879, and closed June 2d, 1880. The whole number of matriculants present during the session was 123; the number of didactic lectures, 680; the number of clinical lectures, 240; the number of clinical cases, all the dispensary affords. There were 35 graduates, as per list; course of study, three full years.

The Homœopathic Medical College of Missouri.—The session of the college opened October 9th, 1879, and closed March 11th, 1880. The whole number of matriculants present during the session was 54; the number of didactic lectures, 440; the number of clinical lectures, 160; the number of clinical cases was 4562; the total number of graduates, 25.

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The New York Homœopathic Medical College of New York City.—The session of the college opened October 7th, 1879, and closed March 5th, 1880. The spring course opened March 9th, 1880, and closed April 23d, 1880. The whole number of matriculants present during the session was 130. Number of didactic lectures during winter session, 622; spring session, 78; total, 700. Number of clinical lectures, winter session, 160; spring session, 33; total, 193. Number of clinical cases presented, winter session, 543; spring session, 60; total, 603. Total number of graduates, 33.

The Hahnemann Medical College of Philadelphia, Pa.—The session of the college opened September 29th, 1879, and closed March 1st, 1880. The whole number of matriculants was 208; the number of didactic lectures, 680; clinical lectures, 120; clinical cases, 1162; total number of graduates, 75.

Cleveland Homœopathic Hospital College, Cleveland, O.—Session opened September 24th, 1879, and closed February 25th, 1880. Matriculants, 130; didactic lectures, 464; clinical lectures, 176; clinical cases, 850; graduates, 49.

The Chicago Homœopathic College of Chicago, Ill.—The session of the college opened September 30th, 1879, and closed April 2d, 1880. The whole number of matriculants present during the session was 80; the number of didactic lectures, 620; clinical lectures, 192; total number of graduates, 20.

The Homœopathic Medical Department of the University of Michigan, Ann Arbor.—The session of the college opened October 1st, 1879, and closed June 30th, 1880. The whole number of matriculants present during the session was 75; number of didactic lectures, about 1000; clinical lectures, about 300; clinical cases, 653; the total number of graduates, 26.

This concludes the reports of the colleges so far as received.

On motion, the reports were accepted.

WILLIS DANFORTH, M.D., Milwaukee, Wis.: Thinking that it would be for the mutual advantage of all the members to have an informal meeting in the nature of a reception to-night, my wife joins me in extending an invitation to the members to meet at our residence.

DR. WALKER, of St. Louis: I move that Dr. Danforth's invitation be accepted.

Seconded and adopted.

THE PRESIDENT: The Board of Censors are now in order, the chairman will report.

F. R. MCMANUS, M.D., of Baltimore: The Board of Censors, through their chairman, beg to offer the names of the applicants I am about to read, their election to be decided by a vote of the Institute. It seems to be a work of supererogation to say anything to the members of the Institute about the importance of electing new members. The board, however, begs to ask, as a favor, that if there shall be any one present who has any objection to

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the election of any candidate whose name is mentioned, that that person will have the good sense and will feel it a duty to make that objection. If not by rising up and standing at the time, to come before the Board of Censors and make it privately. Make it to me as the chairman of that board. I am, as the chairman of your Board of Censors, frequently importuned after our meeting by members writing to know why such a man was elected as a member of the Institute, where he lived, the letter stating this, and that, and all manner of things about the person inquired of. Therefore, I say, if any person has an objection, a valid objection, to the election of a candidate, he ought to have the independence to object to that kind of thing in a manly way, and in a fair way, otherwise afterwards he ought to hold his peace.

The names of the applicants were then read.

THE PRESIDENT: You have heard the report of the chairman of the Board of Censors; what will you do with the report?

F. R. MCMANUS, M.D., of Baltimore, Md.: The Board of Censors asks that the members of the Institute will very carefully examine these applications, and that you will then take a vote on the election of those persons for membership.

THE PRESIDENT: You have heard the report of the chairman of the Board of Censors read; what will you do with it, and the request accompanying it?

L. E. OBER, M.D., of La Crosse, Wis.: I move that the report be received and the applicants named elected.

Seconded and agreed to.

(See complete report of the Board of Censors.)

HENRY C. ALLEN, M.D., of Ann Arbor, Mich.: Are you now prepared to take up the report of the Committee on Publication?

THE PRESIDENT: The matter is left with the Institute.

BUSHROD W. JAMES, M.D., of Philadelphia: I move, sir, that the order of exercises be suspended to take up the report of this special committee.

Agreed to.

THE PRESIDENT: The chairman of the committee will now make his report.

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HENRY C. ALLEN, M.D., Ann Arbor, Mich.:

Mr. President: The report of the Special Committee on the Annual Report of the Committee of Publication will now be presented. Upon an investigation of the causes which have led to the extraordinary delay in the publication of the *Transactions of the World's Homœopathic Convention of* 1876, and the failure of the ex-Secretary to issue the *Transactions* for 1879, we have come to the following conclusions: First, that the delay in the first instance was occasioned by the death of the late Dr. Dunham, who had all the papers in charge; second, that the delay in both cases during the past year has been occasioned by a singular mental and physical condition of the ex-Secretary, very difficult to explain. Although unable to perform the labor of publication, Dr. McClatchey has shown a most singular and unaccountable persistence in keeping the manuscripts from the present Secretary, until June 11th instant, too late for issuance before this meeting. Your committee cannot account for the course of Dr. McClatchey upon any theory, except that of ill health occasioned by overwork, and in view of the eminent services which he has rendered, both to the Institute and to the profession at large, we would advise no censure upon Dr. McClatchey, notwithstanding the aggravated trespass upon our patience. In regard to the course to be pursued to bring out the backlying volumes, your committee would recommend: First, that the *Transactions of the World's Convention* and of the session of 1879 be committed to the hands of the ex-Provisional Secretary, Dr. Joseph C. Guernsey, of Philadelphia, with instructions to publish them with as little delay as possible; second, that the Treasurer be empowered to pay Dr. Guernsey for such editorial and clerical services, not to exceed seven hundred dollars, upon the completion of the work.

All of which is respectfully submitted,

H. C. ALLEN,
J. P. DAKE,
J. C. BURGHER,
Committee.

DR. ALLEN: I may say, Mr. President, that in looking over the facts in the case your committee have come to the conclusion that the easiest way to get out of it is the best way for the Institute and for the profession, and that way will be to put these papers in the hands of Dr. J. C. Guernsey, of Philadelphia, who, by the course he has pursued in the issuance of the *Proceedings of the Pennsylvania State Society*, has shown a particular aptitude in getting out works of this kind, and doing it well. It is a difficult work to do, and very few are adapted to do it. I am also instructed to say that the members of the Faculty of Hahnemann Medical College, and the members of the Hahnemann Medical Club of Philadelphia are now in the receipt of the manuscripts

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of some of these volumes, and have volunteered to assist Dr. Guernsey in this work. In view of the fact that it has been delayed so long, and that the Institute has suffered a great deal in consequence of it, your committee unanimously recommend the adoption of this report.

THE PRESIDENT: You have heard the report of the committee; what will you do with it?

It was moved and seconded that the report of the committee be adopted.

Agreed to.

THE PRESIDENT: The Bureau of Materia Medica, Pharmacy, and Provings will now report.

J. P. DAKE, M.D., of Nashville: Mr. President, the printed programme which you have, and which appears in the announcement of this meeting, shows that this bureau is full of papers. The papers mentioned there will be presented, with the exception of one not received from Dr. Cooper and one not received from Dr. Paine. I have up to this moment received no paper from these gentlemen, and I believe that they are not present. I wish to say before proceeding that some of the papers are short and will not occupy the full fifteen minutes, but some of the papers will exceed fifteen minutes a little, and therefore I ask your indulgence so that the papers may be completed.

A *résumé* of the paper of the chairman was then read.

The first paper in order will be read by Dr. Breyfogle.

W. L. Breyfogle, M.D., of Louisville, Ky., read his paper entitled The Proof of Drug Presence and Power in Attenuations above the Sixth Decimal, as Furnished by the Tests of Chemistry.

C. Wesselhœft, M.D., of Boston, Mass., then read his paper on The Proof of Drug Presence and Power in Attenuations above the Sixth Decimal, as Furnished by the Spectroscope and Microscope.

J. Edwards Smith, M.D., of Cleveland, O., read his paper on The Proof of Drug Presence and Power in Attenuations above the Sixth Decimal, as Furnished by the Spectroscope and Microscope.

Lewis Sherman, M.D., of Milwaukee, Wis., then read his paper on The Proof of Drug Presence and the Power of Attenu-

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ations above the Sixth Decimal, as Furnished by the Tests of Physiology.

J. P. DAKE, M.D., of Nashville, Tenn.: The next paper in order is that furnished by myself on The Proof of Drug Presence and Power in Attenuations above the Sixth Decimal, as Furnished by Analogy from the Field of Impalpable Morbific Agencies.

The paper was read.

J. P. DAKE, M.D., of Nashville, Tenn.: Dr. Cooper had a paper in preparation, but was not able to finish it. The next paper in order will be the paper of Dr. Cowperthwaite. I hope the members of the Institute will listen patiently. I have but a few more papers, but they are very important.

A. C. Cowperthwaite, M.D., of Iowa City, Iowa., then read his paper on The Proofs of Medicinal Presence and Efficacy in Attenuations above the Sixth Decimal, as Furnished by Clinical Experience in the Use of Attenuations Ranging from the Fifteenth to the Thirtieth Decimal.

J. P. DAKE, M.D., of Nashville, Tenn.: The next paper in order will be presented by C. H. Lawton, M.D., of Wilmington, Del.

Dr. Lawton then read his paper on The Proofs of Medicinal Presence and Efficacy in Attenuations above the Sixth Decimal, as Furnished by Clinical Experience in the Use of Attenuations above the Thirtieth Decimal.

THE VICE-PRESIDENT: Discussion on the Bureau of Materia Medica is now in order.

J. P. DAKE, M.D., of Nashville, Tenn.: I also hold in my hand special reports from several gentlemen, which, if time is allowed, I shall read. Dr. Pearson has a valuable one on Typhlitis. Dr. Cowperthwaite; Dr. Fisher, of Indiana; Dr. H. N. Martin, of Philadelphia; Dr. J. C. Morgan, of Philadelphia; Dr. E. A. Farrington, of Philadelphia; Dr. Samuel Lilienthal, of New York; and Dr. J. B. C. Custis, of Washington, have also presented papers.

THE VICE-PRESIDENT: What will the Institute do with the papers presented by Dr. Dake by title?

DR. WALKER, of St. Louis: I move that they be referred to the Printing Committee.

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THE VICE-PRESIDENT: A motion has been made and seconded that they be received and referred to the Committee on Publication.

C. PEARSON, M.D., of Washington, D.C.: Does that motion include a motion to refer to the Committee on Publication.

THE VICE-PRESIDENT: That is the way the Chair understands it.

C. PEARSON, M.D., of Washington, D. C.: I beg leave to say that the paper by Dr. Leighton, of Washington, I have heard, and it is a very interesting case, and it should command the attention of the members of the Institute. If it is not read to the Institute, and not published in the *Transactions*, I would like to have it returned for publication in the medical journals. I feel that it is an important and interesting matter, and one that should not be lost sight of. If the Institute does not want the paper I will publish it in a medical journal. I do not want to take away the property of the Institute, but if it is not of use to the Institute I wish to have it published elsewhere.

THE SECRETARY: I suggest that the authors of the papers present be allowed to read them, and that the papers of those members who are not present be read by title and referred. I will make that as a motion. The Bureau of Materia Medica has solicited papers and received more than we have time to hear read, but it is only fair to the members present that theirs be read. I move, sir, that Dr. Pearson be accorded the courtesy of reading the paper of Dr. Leighton.

Seconded.

Agreed to.

Dr. Pearson then read Dr. Leighton's paper on Typhlitis.

J. P. DAKE, M.D.: All the papers of this bureau are now in.

THE VICE-PRESIDENT: The hour for adjournment has arrived. The Institute is now adjourned until 7 o'clock this evening.

EVENING SESSION.

THE PRESIDENT: The Institute will now come to order. The first thing in order is the closing of the report of the Bureau of Materia Medica, Pharmacy, and Provings. The papers

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have all been presented to you, and they are now open for discussion.

(See Appendix—Discussion.)

On motion the bureau was closed.

THE PRESIDENT: The next business in order is the presentation of the report of the Committee on Medical Literature, Henry M. Smith, M.D., New York, chairman.

HENRY M. SMITH, M.D., New York:

During the last year, 1879, we have taken cognizance of such publications as we have received, in addition to those that were published this year, including the entire list. We have made a report of everything; the journals and various manuscript works and pamphlets, and transactions of societies, announcements of colleges, and everything that had appeared in print. The work has been assigned to various members of the bureau, who have not as yet reported to this organization the result of their labors. It will be completed and passed over to the Secretary.

In the year 1879, on January 31st, there was published in New York an index of the current medical literature of the world. Every publication everywhere printed was noted here. Not only was a notice given of the publications, but all articles of any importance appearing in any journal was noted here in its references. An exceedingly valuable book to those who wanted it, as Dr. Pierson said in regard to Lincoln's story,—It is valuable. There are many homœopathic physicians who wish to know what has been written. There was mentioned here five hundred and seventy odd serial publications. That includes journals, transactions, etc. It professes to give a list of all medical publications, of course including homœopathy, and extracts from homœopathic journals. It mentions thirty-three homœopathic serials; one or two only of the transactions. The foreign list is tolerably complete, but it makes extracts occasionally, and mentions only seven American publications. There are two extracts from American homœopathy. I think that they divided the subject as we have done in our Transactions, putting them under the head of materia medica, obstetrics, therapeutics, surgery, and miscellaneous statistics. These are the articles that are published therein. That part is not yet complete, but will be completed and handed to the Secretary. It is not necessary, Mr. President, I suppose, for the committee to say much about this matter or to take the part in any way of a critic. All that we can do is to make a suggestion along with our proceedings. Inasmuch as the Proceedings of all of our societies, local, State, and national, are containing articles of great value to the profession, greater value possibly than those published in our periodicals when they reach the members and readers, we should have them early, but now they are like an old directory, or they are in such massive form that the members get no time to read them. This was the objection made this year by the members of the American Medical Association, that their vol-

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ume, when it came out, was cumbersome, and they adopted the plan of issuing their Proceedings in sections. Your committee recommend that we follow their example, as it is thought that this will give greater satisfaction. Your committee would recommend that the *Proceedings of the Institute of Homœopathy* be issued to the members at once, as soon as printed, and that the transactions and proceedings that take place during our meeting accompany them. As we have a stenographic report we recommend that the transactions and the proceedings that take place during our meeting be prepared immediately, and issued in a pamphlet form And then the various bureaus, one or possibly more, be joined together, making another section. and that that be sent to the members of the Institute as soon as ready. Mr. Chairman, that is the suggestion of your committee.

DR. MCCLELLAND, Pittsburg, Pa.: I move that the report be referred to the Committee of Publication, and the recommendations be adopted.

Carried.

THE PRESIDENT: The next business in order is the report of the Committee on a Homœopathic Dispensatory, of which J. J. Mitchell, M.D., Newburgh, N. Y., is the chairman.

The chairman of the Committee of the American Institute of Homœopathy, to whom was referred the matter of a Dispensatory, would respectfully report: That in August last, after the meeting in June, 1879, he was apprised of the appointment of the following committee upon that subject, viz.: John J. Mitchell, M.D., Newburgh, N. Y.; T. F. Allen, M.D, New York; H. M. Smith, M.D., New York; F. E Bœricke, M.D., Philadelphia; C. Hering, M.D., Philadelphia; R. J. McClatchey, M.D., Philadelphia; S. Lilienthal, M.D., New York.

Upon the application of the chairman, Dr. H. M. Smith, of New York, immediately forwarded the manuscript of the Dispensatory, which has been in charge of the committee for a number of years.

Upon examination it was found to be contained in seven large scrap books. In these were pasted slips of history, botanical and chemical, of pharmacy, and notices of studies and provings, arranged under the pharmaceutical name of the various drugs in alphabetical order, the whole number included being about 250. Notices of the studies and provings have been gathered from most of our standard publications, and from the foreign and domestic periodicals.

In the department of pharmacy many of the drugs have their manner of preparation very fully and thoroughly presented, but in regard to very many others, probably a majority, it is entirely absent. Most of this work has been done by Dr. H. M. Smith, of New York.

The botanical history of the various herbs, etc., has been furnished by Professor T. F. Allen, M.D., of New York, and, though not complete, is probably the nearest to completion of any of the department of the work.

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The chemical history of the metals and other chemical substances closed with the report made some four years ago by the chairman of your committee upon about one-half of the substances of this nature named in our Materia Medica.

The work of Dr. Dunham is seen in the research as to history, the provings and the studies of the various substances. There is no general introduction, no general rules for pharmaceutical operations, no tables of poisons or antidotes, no record of doses, and, in fact, the general work of a dispensatory is as yet untouched.

After this examination your chairman communicated, either verbally or by letter, with those members of the committee from whom he had reason to suppose he could obtain assistance. He either received no replies to these requests, or they were of such a character as to forbid his placing any reliance upon the members of the committee for essential aid in the matter. Such being the case, and realizing the very great labor that would be required to place the manuscript of the Dispensatory before the Institute in a form that would be at all creditable to it, the chairman did not feel it incumbent upon him to assume the burden of the work with all its responsibility, neither indeed did he deem it proper for him to do so.

The manuscript is now in the hands of the chairman of the committee, and subject to the order of the Institute. He would suggest that, in his opinion, there are two courses open to the Institute, by either of which its wishes can be met: 1st, by placing the MS. in the hands of the compiler of the *U. S. Homœopathic Pharmacopœia*, published by Duncan & Bros., 1878, giving him authority to use such matter as may be new and useful in a new edition of that work; or, 2d, to delegate the entire work to a committee of *one*, who shall be ordered to report the MS. complete at the next session of the Institute in 1881.

It is the opinion of the chairman of your committee that only in one of these two ways can the wishes of the Institute be complied with, and this great need in our school be met.

All of which is most respectfully submitted,

JOHN J. MITCHELL,
Chairman of Committee.

NEWBURGH, N. Y., June 9th, 1880.

DR. SMITH: Mr. Chairman, if I am allowed a few moments I wish to speak in regard to the preparation of the Dispensatory, or rather on the subject of a pharmacopœia.

THE PRESIDENT: Do you wish to discuss that subject?

DR. SMITH: I wish to report more fully on that point. Dr. Dunham was the chairman of the committee, and with his usual care and thoroughness he went to work immediately to get at all the facts in reference to the homœopathic remedies, and, as Dr. Mitchell states, arranged them in alphabetical order, pasting

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them in seven large scrap-books. When his health gave out in 1872, he gave those books into my care, with the request that I would not give them to anybody. Part of that work was my own. The reference to American literature I made. He gave them to me, and I may say for this purpose. When he came back to this country his time, as you know, was entirely engrossed in getting out the Proceedings or in arranging for the World's Homœopathic Convention, at the conclusion of which his labors were finished. Nothing was said about it, and I knew nothing about it. At the next meeting of the Institute I was absent, and one of the members of the committee was appointed chairman. He reported those books were not to be found. Last May, before the meeting of the Institute, at a social meeting, he accidentally remarked that it was strange that those books of Dr. Dunham could never be found, and asked me, for the first time, if I knew where they were? I told him I did, and gave them to him, and he reported to the Institute that he had just found them, and asked to be relieved from the work that was to be done. That work contains a list of all that is printed in homœopathic literature, with a reference to all that is required.

THE PRESIDENT: What will you do with the report of the committee.

DR. ALLEN: I move that it be referred to the Committee on Publication.

DR. I. T. TALBOT, of Boston: Permit me to say a word or two in relation to this subject of a Homœopathic Dispensatory. The matter was introduced to the Institute by Dr. Dunham in 1868. It was then proposed that such a Dispensatory should be prepared under the direction of the American Institute of Homœopathy. A committee was appointed, and that Dispensatory in an unfinished condition has presented itself from year to year to this Institute. I think that twelve years' incubation is quite sufficient, and I move you, sir, that the subject of the publication of a Dispensatory by the American Institute of Homœopathy be dismissed.

I think, like other works of the kind, it should take the course that such works take. That those who are competent should take the editorship of it and do it, and that it should come to us

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on their recommendation. If we appoint a committee we should not be competent to judge of it, while if a person takes the private responsibility of it, and takes it to a publisher, we shall be then in a position where we can buy it or not, as we please. He takes the responsibility of the publication of it. Again, we have stood as an Institute for twelve years in the way of any publisher publishing it, or causing it to be prepared, because it is in the hands of the Institute. Therefore I move that the subject be dismissed.

J. C. BURGHER, M.D., of Pittsburg: I second the motion.

THE PRESIDENT: The motion is to indefinitely postpone action upon it under Dr. Talbot's advice.

DR. KENYON: There is a motion before the house for a reference of the report.

THE PRESIDENT: Dr. Talbot's motion is in order; it will take precedence of the motion made to refer.

DR. T. C. DUNCAN, of Chicago: Perhaps a word here would be in order from me explanatory of the appearance of the work, which would seem to be premature, and taking out of the hands of the Institute this work—a complete Homœopathic Dispensatory. You are well aware that we issued some two or three years ago a small work on the Pharmacopœia. It was done to meet a pressing want, coming from a large number of eclectics who were constantly inquiring where they might learn something about the preparation of homœopathic remedies. That was the reason that work was presented in that form. The work is now out of print, but is being revised. If that work could be incorporated with the work that is being done by this committee, I think it would give us a very satisfactory Homœopathic Pharmacopœia, and it seems to me that something of the kind could be done. We will be very glad either to do one of two things: to take the manuscript and issue a complete and satisfactory work to this Institute, or possibly, I would not say definitely, but I think we could arrange to turn over the matter to the Institute if they propose to go on and make a complete, satisfactory, and reliable Pharmacopœia.

DR. BALLARD, of Chicago: I am rather sorry, Mr. Chairman, to hear this motion, and rather hope that it will be voted down.

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At the last meeting of the Illinois State Society there was a committee appointed to suggest the matter of a complete Dispensatory to the American Institute of Homœopathy, with the hope that they would adopt some means whereby the present preparation of homœopathic medicine might be regulated.

It is impossible now to really rely upon the strength of any particular drug which you may get of any of the pharmaceutists. Some have one standard by which they prepare it, others have another standard, and when I take a preparation of the third decimal the confined grains of the drug are plainly to be seen in it. That is not a proper mode of trituration, and that has been done. So, too, when you feel of that trituration between your fingers, and as you feel it you find these grains, it shows that it has not been properly triturated.

I expected, Mr. Chairman, to present a written report on the point proper before the Institute. Dr. Newman, who is chairman, promised to see to it. I have waited for the report, hence I had not consulted the chairman of this bureau; but it is hoped that some action in this regard will be taken by the American Institute of Homœopathy, whereby the homœopathic profession will know what is the regular standard for the preparation of our medicine.

THE PRESIDENT: The motion is to indefinitely postpone.

THE SECRETARY: I received a communication from Dr. Richard Hughes, of Brighton, England, some time in March, in which he informed me that the British Medical Society proposed publishing a third edition of the *British Homœopathic Pharmacopœia.* He stated also, that he understood that the American Institute of Homœopathy had the *United States Dispensatory* in hand, and requested me to bring this matter before the Institute at the proper time; to endeavor to get this committee, or the Institute, to co-operate with their society in the publication of this third edition. He said the work necessarily would have to go under the name of the *British Homœopathic Pharmacopœia.* But their object was to make it so complete that it would satisfy the entire English speaking and reading portion of homœopathic physicians.

Dr. Hughes said that he would be very glad indeed to receive

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any suggestions from the Institute in regard to the preparation of this work, and he would cheerfully consider any suggestions it might make in reference to it.

THE PRESIDENT: Are you ready for the motion?

The motion to indefinitely postpone the subject of the Dispensatory was agreed to.

THE PRESIDENT: The next business in order is the Bureau of Clinical Medicine, C. Pearson, M.D., of Washington, D. C., chairman.

CLEMENT PEARSON, M.D., Washington, D. C.:

Mr. President, Ladies, and Gentlemen of the Institute: The Bureau of Clinical Medicine, as you are all aware, selected for the papers on this occasion the subject of scarlatina. I did not assign to myself any particular work, as you will see, upon the programme, for the reason that I thought it was very likely that some person, some member of the bureau, might not be present, in which case I proposed to take the place of the absentee in order that the papers of the bureau might be complete. I did not expect to have this task to perform until about two weeks ago, until I received a letter from Dr. Cooke, of Chicago, saying that he could not be here. I am happy to inform the members of the Institute that all the other members of the bureau are present. That they are not only present but have papers, and I think papers that will interest the Institute. I will now read a short paper on scarlatina, assigned to Dr. Cooke. That I give as a reason for reading the first paper myself. I did not expect to read any paper at all. I do it in order to have the papers of the bureau full.

The next paper is on the Diagnosis and Course of its Varieties, Progress and Pathology, by Dr. Lilienthal, of New York.

The next paper is under the head of Contagious Nature, Liability to, and Exemption from, as to Age and Previous Attack, by T. F. Pomeroy, M.D., of Detroit, Mich.

I. T. TALBOT, M.D., Boston, Mass.: I move that when we adjourn, we adjourn to meet at 9 o'clock to-morrow morning.

THE PRESIDENT: Before the motion is put, allow me to say in behalf of our old and venerable friend Dr. McManus, that he wishes to entertain this Institute with some account of his experience in the practice of homœopathy.

DR. EDMONDS: I move that the hour from ten to eleven on Friday be assigned to Dr. McManus.

DR. TALBOT: I second the motion.

Adopted.

On motion the Institute adjourned to meet at 9 A.M.

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THIRD DAY.

MORNING SESSION.

THE PRESIDENT: The Institute will now come to order. The first thing in order is the Bureau of Clinical Medicine.

D. H. BECKWITH, M.D., Cleveland, O.: The Auditing Committee are now ready to report.

THE PRESIDENT: If there is no objection the Auditing Committee will report.

D. H. BECKWITH, M.D.: Mr. President, your committee, after careful examination of the report of our Treasurer, find that the report of last year is correct, and also the supplementary report of the World's Convention.

J. C. BURGHER, M.D., Pittsburg, Pa.: I move that the report be accepted.

DR. OLMSTEAD, Milwaukee, Wis.: I second the motion.

The question being on the motion to receive the report of the committee, it was agreed to.

THE PRESIDENT: Is there any miscellaneous business before the chairman of the Bureau of Clinical Medicine takes the floor? If not we shall proceed with the Bureau of Clinical Medicine.

E. C. FRANKLIN, M.D., Ann Arbor, Mich.: Mr. President, I believe it was the rule of the Institute that there should be a report of the colleges. Yesterday morning I believe there was a partial report of the colleges presented to the Institute. I can only make a partial report, and I would ask the favor of the Institute for an indulgence of a few days, that I may be able to perfect my report in reference to the Homœopathic Department of the University of Michigan. I am unable to report the number of didactic lectures and clinical lectures. I think that the report should be got out with accuracy. I have no means at the present time to get at the exact number of students. If the Institute will be kind enough to allow me, I will present that report. I believe there is another college also in the same situation as ours. I think it will be gratifying to our college as well as to the New York college, and we will be able to present a

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correct report. I ask permission of the Institute for the time, for ten or fifteen days as the case may be, to perfect this report for the *Transactions* of the Institute.

PEMBERTON DUDLEY, M.D., Philadelphia: I move that the colleges delinquent in their reports be allowed one week after adjournment to perfect their reports and forward them to the Secretary.

Seconded by A. E. Small, M.D., Chicago. Adopted.

DR. T. C. DUNCAN: I move that the report of the colleges be made by the Bureau of Organization, Registration, and Statistics. I think then there would be no confusion.

The motion was seconded and adopted.

DR. I. T. TALBOT, Boston: Mr. President, Inasmuch as the adoption of the recommendation of the Committee on Medical Literature, in regard to the issuing of the *Transactions* in sections, has led to some misunderstanding, I move a reconsideration.

Agreed to.

DR. SCHNEIDER, Cleveland: Mr. President, I believe in allowing the Secretary to issue the *Transactions* in one volume. I move, sir, that the recommendation be laid on the table.

DR. MCMANUS, Baltimore: I second the motion.

Adopted.

DR. F. R. MCMANUS, Baltimore: The Board of Censors beg leave to report. Report received and applicants elected. (See *Complete Report of Board of Censors.*)

DR. MCMANUS: We would say if there are any applications they should be handed in at once. There is a little circumstance connected with the election of these parties which it is necessary for us all to know, that the election of members here is only ratified by the action of Professor Kellogg, Treasurer. It is requisite that the dues should be paid, and the election is not complete until the Treasurer is attended to.

THE PRESIDENT: The chairman of the Bureau of Clinical Medicine has the floor, and will now complete his report.

DR. CLEMENT PEARSON, Washington: I would present the following additional papers:

The Contagious Nature of Scarlatina; Liability to, and Exemption from, as to Age and Previous Attacks. Dr. T. F. Pomeroy, Detroit.

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Dissimilarity to Diphtheria and Other Cutaneous Diseases. Dr. J. P. Mills, Chicago.

Belladonna and Other Prophylactics, and for What Varieties; Influence of Seasons, Climate, etc. Dr. O. P. Baer, Richmond, Ind.

Treatment of its Varieties and Symptoms. Dr. A. Lippe, Philadelphia.

My Experience in Scarlatina. Dr. S. Lilienthal, New York.

Latent Medication. Dr. P. P. Wells, Brooklyn.

The papers were read, and on motion they were accepted and referred to the Committee on Publication.

Dr. Ludlam: I want to offer a resolution which I believe will bring forth more discussion.

Whereas, We believe that by doing the work of this Institute in sections much time would be saved, and a more thorough consideration and discussion of the subjects secured, and a larger share of the professional experience of its members gleaned and recorded, therefore be it

Resolved, That from this time forward the annual meeting of this body shall consist of one general morning session daily for the transaction of the business of the Institute, and that during the afternoon or evening of each day the bureaus shall have their sectional meetings, for the more full and complete performance of their duties.

Dr. I. T. Talbot: I second the motion.

R. Ludlam, M.D.: The reason I offer this resolution is that we come here and listen to long papers and have no discussion. We have listened to many papers here which are of no special importance to us. I mean to those who devote their attention to special subjects. There are many who are interested in special work. This can only be done by those who devote their whole time to the subject. Another reason is that those who have had large experience in the different departments, under the practice of what is termed specialties, desire to come here and state their experience. We want something more than what is contained in papers to go into the publication of a volume of our *Transactions*. We want to have the experience, the live experience, of members throughout the country. I honestly believe that we should have four times the attendance upon the meetings of the

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Institute by means of this plan, and have ten times the interest in our transactions.

O. P. BAER, M.D., Richmond, Ind.: I would suggest that papers be not read *in extenso*, but only a synopsis given.

R. LUDLAM, M.D.: The trouble will be just the same. The time will be consumed by the synopsis of different papers, and no result will be reached.

Question being on the resolution of Dr. Ludlam, it was agreed to.

J. P. DAKE, M.D.: I move that this be made a By-Law instead of a resolution.

Agreed to.

I. T. TALBOT, M.D., Boston, Mass.: I have a resolution to offer. I think it will take but a moment. I wish to ascertain the views of the members present. I wish to have their views expressed. We all know that next year there is to be in London an imitation of the convention held in Philadelphia, called the International Homœopathic Congress, and it has been recognized on the part of this body. I therefore offer this resolution:

Resolved, That the American Institute of Homœopathy cordially indorses the proposition of the homœopathic physicians of Great Britain to hold an International Homœopathic Congress in London, in July, 1881, and that the General Secretary of this Institute be directed to furnish credentials as delegate to any member of the Institute in good standing who may attend such Congress.

Resolved, That the President appoint a committee of three, to make suitable arrangements for the attendance of members on the International Homœopathic Congress in July, 1881.

Motion of Dr. Talbot was seconded by several. The question being on the motion of Dr. Talbot, it was agreed to.

THE PRESIDENT: The committee will be I. T. Talbot, M.D., E. M. Kellogg, M.D., Bushrod W. James, M.D.

THE PRESIDENT: The chairman of the Bureau of Clinical Medicine has the floor.

T. C. DUNCAN, M.D., Chicago, Ill.: I move that we proceed with the regular order of business. The next business in order is the Bureau of Microscopy and Histology.

CONRAD WESSELHŒFT, M.D., Boston, Mass.: Mr. President, the chairman of the Bureau of Microscopy and Histology,

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Dr. Alling, is absent. His report is not here, and it is partly owing to my fault, as he asked me if I would make the report for him. I did not expect to come until within a few hours of my doing so, and I have not his report here. He asked me to take charge of the bureau according to the best of my ability, and I promised to do so. Dr. J. Edwards Smith, a member of this bureau, told me that he would make a report, a short report, which I hope he will now do; and I am myself prepared to make a very brief report, which will not occupy the members very long and, at the same time, may interest them somewhat.

The papers of Drs. J. Edwards Smith and C. Wesselhœft, were then presented and read.

On motion of Dr. J. P. Dake the papers were received and referred to the Committee of Publication, and the bureau closed.

THE PRESIDENT: The chairman of the bureau for the coming year will be Dr. J. Edwards Smith, of Cleveland, Ohio.

The Chair wishes to announce your Necrologist for the coming year. The appointment will be H. D. Paine, of New York.

THE PRESIDENT: If there is no other business of special importance, we will take up the special order assigned for this hour. The first thing is the selection of the time and place for the next meeting of the American Institute of Homœopathy.

I. T. TALBOT, M.D., Boston, Mass.: I move that the time and place of the next meeting of the American Institute of Homœopathy be referred to the Executive Committee of this Institute, with instructions to make arrangements for such place, near or in New York city.

The question being on the motion of Dr. Talbot, it was carried.

THE PRESIDENT: The next thing in order is the election of officers. The proper mode of accomplishing this business will be, first, by the nomination of the candidates. Nominations for President of the American Institute of Homœopathy are now in order.

I. T. TALBOT, M.D., Boston, Mass.: It is my pleasure and honor to nominate for the office of President a man whom we all know and honor, whom we met last year, and whose cordial reception and kindly feeling toward the members of the Institute

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is well known, who has a noble spirit, who has a generous manner, who has executive ability, and whose position in the profession we all take pride in. I nominate for President J. W. Dowling, of New York. (Great applause.)

E. C. FRANKLIN, Ann Arbor, Mich.: I rise to second the nomination of Dr. Dowling, of New York, and I am pleased to know that such a gentleman has been brought before this Institute for the office of the next President of the Association. Dr. Dowling is well known, and it is not necessary for me to say one word in his behalf. The word comes from Boston that he is acknowledged and that he is recommended by every one who knows him. Michigan shakes hands with Boston and indorses the recommendation, and when I come forward I hope the West will come up in solid phalanx. Come to the feast prepared by Dr. Dowling. (Applause.)

GEORGE A. HALL, M.D., Chicago, Ill.: If there are no other nominations, in order to expedite the time and get through with our proceedings I move that the Secretary cast the ballot for Professor Dowling.

Agreed to.

The vote was accordingly cast by the Secretary.

R. LUDLAM, M.D., Chicago, Ill.: I find that the unanimous vote of the Institute, Mr. President, is for Dr. Dowling.

Dr. Dowling was then called for, and came forward in the midst of general acclamation.

THE PRESIDENT: Members of the Institute, I have great pleasure in presenting to you Dr. Dowling, your President-elect of the American Institute of Homœopathy.

J. W. DOWLING, M.D., New York: Mr. President and Members of the American Institute of Homœopathy: This is more than I expected, and more than I can bear. I appreciate the honor which you have conferred upon me, and pledge myself, at the sacrifice of any personal interests, to work hard for the interests of the American Institute for the advancement of homœopathy throughout this entire land, and abroad too. When I look around me and see the venerable forms of these gray-headed veterans, who have for more than a third of a century sat at election deliberations, men of my own age, old in the practice of our

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school, and some of them younger men, graduates of the college which I represent, and last but not least, the ladies too, enthusiastic, hard-working women practitioners, who, with a united voice, have elected me to this exalted position, I cannot but feel truly grateful for the honor conferred. I know myself far better than you know me, and if, in the administration of this high office, I shall make mistakes, rest assured they will not be from the want of a desire to do right, but will be simply errors of judgment, emanating from a desire to do justice to all. As the steel, once touched by the magnet, always turns in the same direction, so my heart, which has been touched by your confidence and your friendship, will always turn towards each and every one of you. (Applause.)

Again, from this heart, which is full to overflowing, I thank you.

THE PRESIDENT: The next thing in order is the nomination of a candidate for the office of Vice-President.

D. H. BECKWITH, M.D., Cleveland, O.: Mr. President, I wish to present before you to-day the name of a physician whom you all know, a man whose genial face is ever present, a man who has risen before this Institution and has been second to none in point of measurement of scientific opinions, a man who, in his style and make up, is a man equal to the President excepting in age. Sir, I present before you the name of William L. Breyfogle, of Kentucky. (Applause.)

THE PRESIDENT: Dr. Breyfogle is nominated.

GEORGE A. HALL, M.D., Chicago, Ill.: I rise for the purpose of seconding the nomination. It affords me very great pleasure to do so. My personal acquaintance with Dr. Breyfogle has been intimate for some time. Though young in years he is ripe in experience; a man thoroughly qualified in his profession, a gentleman at all times, and a good presiding officer. I believe that we should enhance the interests of the American Institute of Homœopathy to elect him one of the presiding officers at our coming meeting.

THE PRESIDENT: Are there any other nominations?

D. S. SMITH, M.D., Chicago, Ill.: I move that the nominations be now closed.

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Agreed to.

I. T. TALBOT, M.D., Boston, Mass.: If there is no other person to be nominated, to save the time, I move you, sir, that the Secretary cast the vote of the Institute for Dr. Breyfogle.

Agreed to.

The Secretary then cast the ballot for Dr. Breyfogle.

R. LUDLAM, M.D., Chicago, Ill., Teller: This vote is also unanimous. Mr. President, Dr. Breyfogle is unanimously elected Vice-President of this Institute.

W. L. BREYFOGLE, M.D., Louisville, Ky.: Ladies and Gentlemen of the American Institute: Like Dr. Dowling, I am almost too full for utterance. I had no thought of running for an office this morning. I have always considered myself one of the younger members, and had no aspiration of that kind; therefore I heartily appreciate the compliment and honor you have done me. I only say I indorse fully the sentiments uttered by our worthy President who has addressed you, and thank you for this high honor. Again I thank you, gentlemen, from the bottom of my heart, for this high honor.

THE PRESIDENT: You will now proceed with the election of the officers of this Institute. Nominations are in order.

R. LUDLAM, M.D., Chicago, Ill.: Mr. Chairman, I rise to nominate a man known to all as one of the best secretaries in the universe. I refer to our Grand Worthy Scribe, Dr. Burgher, of Pittsburg.

The nomination of Dr. Burgher was seconded by several, Dr. Smith and Dr. Dake both rising for the same purpose.

On motion, the nominations were closed.

D. S. SMITH, M.D., Chicago, Ill.: I move you that Dr. Ludlam, of Chicago, be authorized to cast the ballot.

Agreed to.

Dr. Ludlam accordingly cast the ballot.

R. LUDLAM, M.D., Chicago, Ill., Teller: Mr. Chairman and Gentlemen of the Convention: It gives me a great deal of pleasure to announce that this vote is also unanimous.

J. C. BURGHER, M.D., Pittsburg, Pa.: I most heartily and most cordially thank you for this additional evidence of your confidence and esteem. You know but little of my work as

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Secretary. You have taken me on trust; I hope you will not be disappointed. I have no pledges to make; I propose to do the work before me in the best way I can, and with as little delay as possible. Again I thank you for your unanimous re-election.

THE PRESIDENT: The next business in order is the election of a Provisional Secretary. Nominations for that office are now in order.

I. T. TALBOT, M.D., Boston, Mass.: I nominate Dr. J. H. McClelland, of Pittsburg, for Provisional Secretary.

ALVIN E. SMALL, M.D., Chicago, Ill.: I move that the nominations be closed.

Agreed to.

D. S. SMITH, M.D., Chicago, Ill.: I move that the Vice-President, Dr. Hall, cast the vote of the Institute for Dr. McClelland.

Agreed to.

R. LUDLAM, M.D., Chicago, Ill., Teller: I would report, Mr. President, that this vote is unanimous for Dr. McClelland for Provisional Secretary of the American Institute of Homœopathy.

J. H. MCCLELLAND, M.D., Pittsburg, Pa.: Mr. President and Ladies and Gentlemen: I also thank you for the high and mighty office to which you have elected me. I tell you I am going to back Dr. Burgher.

THE PRESIDENT: The next thing in order is the election of a Treasurer.

H. M. SMITH, M.D., New York city: I rise with considerable modesty, and I have a good deal of it, and I have got it with me now. As Dr. Franklin said, the East was entitled to the Presidency, and the West ought to have the Vice-presidency. Between the States we have a secretary and a provisional secretary. Now the East is represented by that little place called New York, where we are to meet next year. They are not afraid of work; they are willing to take some work, as we have done all along. I refer now to the young man who has had some experience with dollars and cents, and we are willing to back him up a little longer, and, with a little experience, we think he will make a tolerably good treasurer. The gentleman

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I refer to is the well-known Dr. E. M. Kellogg, of New York city. (Great applause.)

THE PRESIDENT: Is there any second to this nomination?

J. P. DAKE, M.D., Nashville: I rise to second the nomination of Dr. Kellogg. I do it with a great deal of confidence, because I have been on the Auditing Committee once in awhile, and have always found the doctor's accounts perfectly straight.

HENRY C. ALLEN, M.D., Ann Arbor, Mich.: I move that the nominations be closed, and that the Teller be authorized to cast the ballot.

Agreed to.

R. LUDLAM, M.D.: I have the pleasure to announce that this vote is also unanimous.

E. M. KELLOGG, M.D., New York city: Well I never, Mr. President, saw a body of men and women who so welcomed a dun. I have read that some men were born to greatness, others achieve greatness, and still others have greatness thrust upon them. As you know, I have been in a declining state of health for several years, and I announced emphatically last year that I would not serve another term of fourteen consecutive years. I think that my time is about out, and I had better drop the third term business, as the third term sentiment has become very obnoxious of late, and I can only say that I have consented to work only one more year in consideration of the immense amount of work which this year will entail upon the Treasurer. I am confident that we will have in the hands of all the members, before the close of this present year, all of the back Proceedings, including those of the World's Convention, upon which I have answered, I believe, thousands of letters. I shall of course have to do a great deal of work, and I have accepted this office at your hands merely to do the hard work which is involved. I can only promise, as I have done for the last fourteen years, that I will crowd you all with the sharpest kind of a stick from this day henceforth for your dues.

THE PRESIDENT: The election of the Board of Censors is now in order. Nominations will be received.

DR. TALBOT: I nominate as chairman of the Board of Censors a man who has always proved faithful to his duties, and has had

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some little experience in the matter, and in whom we feel perfectly safe that the duties will be well performed. I refer to Dr. F. R. McManus, of Baltimore.

Nominations for additional members of the Board of Censors were made, and on motion the nominations were closed.

Dr. R. Ludlam, Chicago, and Dr. H. C. Allen, Ann Arbor, Tellers, made the following report: 70 votes cast. The following members of the Institute are elected as the Board of Censors: F. R. McManus, Baltimore, chairman; R. B. Rush, Salem, Ohio; C. T. Canfield, Titusville, Pa.; P. G. Valentine, St. Louis; D. S. Smith, Chicago.

Dr. McManus: Ladies and Gentlemen: I think that if there ever was occasion for the expression on the part of the chairman of the Board of Censors, it is at this time, in regard to my election to the chairmanship of the Board of Censors. I feel that the natural infirmities of age, associated with my long, long servitude in the Institute, will soon render me incapable of the fulfilment of the duties of the office for which you have so kindly selected me. Nevertheless, I must say, and I acknowledge it with pleasure, that my vanity is very much excited by this tribute of the Institute to the fidelity with which I have always served you in the same position. I accept again, and I do it because it is due to the friends who have nominated me, and supported me. I do it on account of the confidence that it exhibits in my administration of the office, which is a very important one. I do it for you to perpetuate the advantages to the several members of this Institute, and to preserve as long as I can this glorious institution raised as a tribute and honor to Hahnemann and to homœopathy.

The President: The first thing in order is the Foreign Correspondence, Dr. W. H. Winslow, Pittsburg, chairman.

Dr. W. H. Winslow:

Mr. President and Members of the Institute: I have not received a word from any of the members of my committee, and therefore I cannot recommend their reappointment.

I am happy to report that an American student has taken honors abroad. Dr. S. F. Shannon, of Pittsburg, Pa., a student of Dr. J. C. Burgher, and a graduate of the Hahnemann Medical College of Philadelphia, has taken a

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prize in Materia Medica, amounting to £10, at the London School of Homœopathy.

Dr. A. C. Pope, of London, England, in a communication to your committee, says: "I see by the circular of the Institute of Homœopathy that, at the Milwaukee meeting, delegates are to be appointed to attend the International Homœopathic Convention, to be held in London in 1881. Now, if you won't think it too awfully presumptuous for a Britisher to give a hint to an American citizen,—unless to a whole crowd of them,—permit me to suggest that you appoint as delegates the entire body of members of the Institute. Let us have the entire Institute, from the earliest living member down to the most recent admission, in London next year.

"I wish I could be at Milwaukee to propose it and to enjoy all the pleasures of Lake George over again; the remembrance of them is fresh and green.

"But, alas! for a Britisher to expect a pleasure so great as attending a meeting of the American Institute of Homœopathy more than once in a lifetime is to expect too much."

Dr. Richard Hughes, of Brighton, England, transmits the circulars appended, and writes amongst other things: "I shall be very glad if, in your capacity as chairman of the Committee on Foreign Correspondence, you will bring the subject of the International Homœopathic Convention fully before the members of the Institute.

"I hope, under the new Secretary, editors of journals in foreign countries will receive copies of the *Transactions* regularly for review.

"Pray convey my brotherly regards and best wishes to the Institute, whose honorary membership is one of the distinctions of which I am most proud."

LONDON, ENGLAND, January, 1880.

To Dr. W. H. Winslow, Chairman of the Committee on Foreign Correspondence, American Institute of Homœopathy.

DEAR COLLEAGUE: At the close of the World's Homœopathic Convention, which met in Philadelphia, in 1876, it was determined to hold a similar meeting every five years in some principal city of Europe or America; and a general wish was expressed that the seat of the next gathering might be London.

On this determination and desire being communicated to the Congress of British Homœopathic Practitioners meeting in Bristol, in September, 1876, it was unanimously resolved that such a convention should be held in London in 1881, and that the Congress would undertake the arrangements necessary for the purpose. A committee, consisting of the undersigned, was thereupon appointed to draw up a plan of proceeding; and its report, which is herein inclosed, was accepted at the Congress of 1877, and the committee reappointed, with instructions to obtain adhesions and contributions.

The latter, viz., reports of progress and papers to be discussed at the meetings, we are soliciting from individual physicians practicing homœopathically throughout the world. But we now request your good offices towards interesting the American Institute of Homœopathy in our proposed gathering,

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by bringing the subject before it, and also towards making it known to the homœopathists of your country in such a way as you may think best.

The exact time and place of meeting, with the office-bearers, etc., will be finally decided at the Congress we shall hold in September, 1880; and information thereof will be duly forwarded to you, and published in all British homœopathic journals.

Hoping to hear from you ere long, and to find your services enlisted in the cause, we remain,

Very faithfully yours,

R. E. DUDGEON, *Chairman.*
W. BAYES,
A. CLIFTON,
A. C. POPE,
R. HUGHES, *Secretary.*

All communications to be addressed to the Secretary, Dr. Hughes, Brighton, England.

Report of the Committee appointed to make arrangements for holding a "World's Homœopathic Convention" in London in 1881. *Presented to and adopted by the British Homœopathic Congress meeting in Liverpool, September*, 1877.

Your committee beg to report that they have had several meetings; and, after much consideration and in conference with the lamented President of the last convention, Dr. Carroll Dunham, have agreed upon the following recommendations, which they present for the acceptance of the present Congress:

"*Scheme for the World's Homœopathic Convention*, 1881.

"1. That the convention shall assemble in London at such time, and during such number of days, as may hereafter be determined.

"2. That this meeting take the place of the Annual British Homœopathic Congress, and that its officers be elected at the Congress of the preceding year; the convention itself being at liberty to elect honorary Vice-Presidents from those foreign guests and others whom it desires to honor.

"3. That the expenses of the meeting be met by a subscription from the homœopathic practitioners of Great Britain; the approximate amount to be expected from each to be named as the time draws near.

"4. That the expenses of printing the *Transactions* be defrayed by a subscription from all who desire to possess a copy of the volume.

"5. That the convention shall be open to all medical men qualified to practice in their own country.

"6. That all who attend shall present to the Secretary their names and addresses, and a statement of their qualifications; and, if unknown to the officers of the convention, shall be introduced by some one known to them, or shall bring letters credential from some homœopathic society, or other recognized representative of the system.

"(*a.*) That members of the convention, as above characterized, shall be at liberty to introduce visitors to the meetings at their discretion.

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"7. That the committee be authorized to enter into communication with physicians at home and abroad to obtain:

"(*a.*) A report from each country supplementary to those presented at the convention of 1876, recounting everything of interest in connection with homœopathy which has occurred within its sphere since the last reports were drawn up.

"(*b.*) Essays upon the various branches of homœopathic theory and practice, for discussion at the meetings, and publication in the *Transactions;* the physicians to be applied to for the latter purpose being those named in the accompanying schedule.

"8. That all essays must be sent in by January 1st, 1881, and shall then be submitted to a Committee of Censors for approval as suitable for their purpose.

"9. That the approved essays shall be printed beforehand, and distributed to the members of the convention, instead of being read at the meetings.

"10. That for discussion the essays shall be presented singly or in groups, according to their subject-matter, a brief analysis of each being given from the chair.

"11. That a member of the convention (or two, where two classes of opinion exist on the subject, as in the question of the dose) be appointed some time before the meeting to open the debate, fifteen minutes being allowed for such purpose, and that then the essay, or group of essays, be at once opened for discussion, ten minutes being the time allotted to each speaker.

"12. That the order of the essays be determined by the importance and interest of their subject-matter, so that, should the time of the meeting expire before all are discussed, less loss will have been sustained.

"13. That the chairman shall have liberty, if he sees that an essay is being debated at such length as to threaten to exclude later subjects of importance, to close its discussion.

"14 That the authors of the essays debated, if present, shall have the right of saying the last word before the subject is dismissed.

"15. That, as at the first convention, the subject of the essays and discussions shall be:

"(*a.*) The Institutes of Homœopathy.
"(*b.*) Materia Medica.
"(*c.*) Practical Medicine.
"(*d.*) Surgical Therapeutics, including diseases of the Eye and Ear.
"(*e.*) Gynæcology."

At a subsequent meeting of the committee, it was determined that the gathering shall be known as the "International Homœopathic Convention."

Dr. A. Claude, of Paris, France, has sent three copies of the *Bulletin de la Société Médicale Homœopathique de France*, containing his account of the Epidemic of Yellow Fever in the United States, which, by his request, I present to the President of the Institute. He has also transmitted the fol-

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lowing interesting essay, entitled The State of Homœopathy in France, which I have translated into English; and now proceed to read:

PARIS, FRANCE, June 1st, 1880.

DR. W. H. WINSLOW, *Chairman of the Committee on Foreign Correspondence, American Institute of Homœopathy.*

DEAR COLLEAGUE AND FRIEND: I regret exceedingly that your letter, in arriving so late, has deprived me of the pleasure of sending you a communication worthy of the friendship which I bear you and the learned assembly to which you are going to present it. Your letter reached me this afternoon, and, in the six hours remaining before the departure of the foreign mail, it is impossible to classify and condense the materials which I need, and I must depend entirely upon my memory.

You ask me for a report upon the actual state of homœopathy in France, and upon its progress in this country.

If by progress, you mean that official confirmation which the government gives, in placing her stamp upon the new doctrines, and in admitting their partisans into the ranks of her administration, Homœopathy is still in France the great unknown—the grand delusion of the commencement of this century. But it is doubtless not at this point of view that you place yourself in order to judge of the advancement of our dear science. Little by little Homœopathy penetrates and creeps in everywhere, and under its influence French Allopathy modifies its therapeutics and abandons its antique barbarism. It would require a whole book to write up this subject. The things they borrow from us are numerous, and would make one of the most interesting chapters of this book, which you could write in America, as well as we could, and about which one of the presidents of the American Institute of Homœopathy spoke so well a few years ago. The abstractions are made sometimes unconsciously, but they show most generally the seal of bad faith. One journal, *Le Lyon Médical* has become the principal agent of this smuggling, and it rarely publishes a number without giving, as a great discovery, the use of one of the agents of our Materia Medica.

Gelsemium has become a remedy for neuralgia in the hands of the Allopaths, who make use now of Bryonia, Drosera, Cochineal, Hepar sulph., etc., just as we do.

M. Planat, of Nice, recommended last year Arnica in the furuncular diathesis, and, a few days ago, M. Herard, in his annual report to the Academy of Medicine upon epidemics, mentioned the observations of one of his allopathic brethren, M. Durand, relative to the prophylactic virtues of Belladonna in scarlatina.

One of the theses, presented in the beginning of the year to the Paris Faculty of Medicine, was devoted to the employment of Thuja against vegetations. The author had the honesty to mention Homœopathy. The most prominent fact is, the investigation in regard to therapeutic diagnosis by the aid of metallo-therapie—a method which had its great beginning in the

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Faculty and in the Academy, and of which the paternity is due to one of our own men, to the deceased and lamented Dr. Perry, well known by M. Burq, the pretended discoverer.

Our medicines and our methods of applying them are appropriated every day without giving us any credit. Nevertheless, an important event has just occurred: a great part of the professors of the School of Medicine at Rennes has just hoisted our flag openly. What will be the effect of this conversion, time alone will tell.

However it may be, French Allopathy occupies the hospitals, the faculties, the academies, the places salaried by the state, and its resistance, in losing all doctrinal significance, is only more determined.

Our nosocomial resources are precarious, ridiculous in comparison even with those you possess in the United States; a hundred beds are divided between three hospitals: the St. Jacques and the Hahnemann, at Paris, and the St. Luke at Lyons. These establishments owe their existence and support entirely to the contributions of our patients, and to our personal ministrations.

An episode will make you appreciate the intensity of allopathic hate. A bequest of 30,000 francs was made in favor of the Homœopathic Society of France by one of its deceased members, Dr. Granier, of Nîmes. This sum should have been applied for the benefit of the St. Jacques Hospital, of which that society is the manager. The French law does not recognize civil rights in associations, that is to say, the right to appear in a court of justice, to succeed to an estate, or to unite in societies, having a kind of investiture, that we may call the acknowledgment of public utility, and which is granted only by the Council of State, after a minute and thorough investigation. Some of the Councilors of State are our patients; the Municipal Council of Paris, the Council of the Prefecture of the Seine, and of the Board of Charities were neutral; if not favorable, at least not hostile to the recognition of the Society as an establishment of public utility. The right was just about being accorded, when the signature was suddenly withdrawn from the decree of approval.

The Academy of Medicine, the General Association of French Physicians, had summoned the medical deputies and senators to act with all their influence upon the minister, in order to make him reverse his decision.

The decree was revoked, and six months later the Hospital of St. Jacques was alone recognized as an establishment of public utility. A simple question of formality, but one that throws a disagreeable light upon the acts of French Allopathy. This meanness was a marvellous lesson to the General Association of French Physicians. It was necessary to act; our society was convened, and it was decided to send a protest to the minister, in order the better to enlighten his alarmed conscience. No one could better undertake this task, than Dr. Gonnard, whom you have seen at the Congress of the Trocadero. You know his grave and elegant diction, his perfect logical conception, and rigidly exact expression. Our *confrère* did not lead the question upon the doctrinal or scientific domain exactly, because a minister is not a pontiff for the promulgation or excommunication of dogmas. He confined himself to the facts, and demonstrated by statistics what services

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our modest asylum rendered to the needy population; then he plead for those great principles of tolerance and liberty, which have been acclimated with so much difficulty amongst us. It was necessary to read those pages, which have the savor of a pamphlet, and which some day will be mentioned in the literature of our country. However poor in money and clinical resources our hospitals may be, they dispense, nevertheless, to those students and doctors of medicine, who frequent them from time to time, ideas that bear their fruits, and assure us of recruits in the future.

Connected with these hospitals are free consultations for out-patients. An innovation, due in part to my initiation, has been introduced in the service of the consultants of the St. Jacques Hospital. For two years the consultations of the forenoon have been divided between six physicians, who each has his day, while before the service was performed consecutively during three months by the same doctor. A notable increase has resulted from this, and an advantage to the patient, who can now be attended by the same physician throughout the year. The increase in receipts from the sale of medicines has demonstrated that my proposition was reasonable. The system has since been applied to the Central Dispensary, a new institution established in the centre of Paris, under the auspices of St. Jacques Hospital and the Homœopathic Society. There are besides seven other free dispensaries in Paris. I have not the figures before me, but I do not believe I exaggerate in saying, that nearly 50,000 free consultations are given every year in Paris. You will be able to judge from this of the progress that we are making among the working classes, when you remember there are only about seventy physicians in the capital practicing Homœopathy openly.

French Homœopathy has two centres, or established unions. One, the Homœopathic Medical Society of France, has the most members, and in the tolerance of its eclecticism admits without distinction the partisans of high dilutions, as well as those of low attenuations. A great part of the members of the journal *l'Art Medical* belong to this society, which has for an organ the *Bulletin de la Société Médicale Homœopathique de France*, a monthly issue, which has excellent contributors, and publishes the minutes of the society meetings. As the friendly confidence of my *confrères* has intrusted the conduct of this journal to me for some years, you will permit me to drop this subject.

One of the most important questions, which has been agitated during the past year by our society, is without doubt the reconstruction of the Materia Medica. Frenchmen are, whatever my excellent *confrère* and friend, Dr. Ozanam, may have said, little given to the making of pathogeneses. We are too few in numbers to be able to enter upon this kind of experimentation, and our critical minds are a little too severe for the long enumerations of symptoms. I will add even, and I hope my words may not be wrongly construed, because I have as much admiration for Hahnemann as his most fanatical partisans, I will add even, that the form of presentation adopted by our master in his *Materia Medica* and his *Chronic Diseases* has been a great obstacle to the diffusion of his doctrine in our country. The fault so keenly felt has been perpetuated in numerous works, the most recent of which is that of my

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venerable and learned friend, Dr. Espanet, upon *Belladonna.* In a most interesting introduction, Dr. Espanet has placed the rules relative to the adoption, or the rejection of symptoms enumerated, and has given a new plan of classification. The society devoted several sessions to the discussion of this work, and at the beginning I broke a lance in favor of a theory which was in old times very dear to me, and of which Baglioi had furnished the idea—I wish to say, the clinical history of the medicine in respect to the chronological order of its symptomatic phenomena, without paying any attention to the arbitrary framework of an anatomical or physiological nomenclature.

It was necessary for me to withdraw quickly from the contest, and masters more qualified than myself—Jousset, Cretin, Gonnard—descended into the arena. You will find in our minutes an official echo, but very just, of these discussions.

The second established union to which I made allusion above is the Federative Hahnemannian Society, which has for an organ the *Bibliothèque Homœopathie.* The members of the group prefer in general the high dilutions, and they gather recruits especially among those whom we may designate as purists. An unexpected and regretted death, that of Dr. Pitet, helped to bring about the publication of the *Bibliothèque*, of which Dr. Chargé is the editor most in authority. Being an absolute partisan of individualization, Dr. Chargé has recently given a most remarkable study on Cephalalgia and Vertigo. Dr. Leboucher has brought himself into notice by his views and sharp attacks against Allopathy. *L'Art Medical*, of which Dr. Jousset is the editor-in-chief, does not belong to a society. It is the organ of a doctrine of which Dr. Tessier, physician of the St. Marguerite Hospital during his life, was the propagator.

L'Art Medical maintains the theory of specific diseases, and of particular predispositions; it is very busy with pathology, and is very advanced in its catholicism, as one can see by its epigraph, borrowed from an encyclical letter of Pius IX. Aside from its philosophical opinions, one must acknowledge that this journal, by its scientific tone, does real service for our doctrine, and has gained it numerous proselytes.

The Hahnemann Hospital had formerly an organ, *l'Hahnemannisme*, directed by M. Simon, which defended the theories developed with such a remarkable *mœstria* by M. Leon Simon, Sr., in his *Leçons de Medecine Homœopathique*, published in 1835.

If *l'Hahnemannisme* now appears only at rare intervals, the zeal of its partisans, and of the physicians of the Hahnemann Hospital, is always at high tide.

I wished, in closing, to touch upon the teaching of homœopathy in France. The Congress of 1878 had placed upon the homœopathic physicians of Paris the organization of this service. To the present time there have only been fruitless attempts, which it would be of little interest to mention. But the Central Dispensary has not hesitated to become a centre of very important teaching. Time fails me to treat this question as it deserves. Let me only say to you that, by the nature even of our political and social organi-

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zation, it is among the physicians, and not among the students, that we must recruit our pupils.

It is necessary to mention our scientific productions, but the learned Dr. Ludlam, of Chicago, has undertaken the task of making you acquainted with the *Leçons Cliniques*, by Dr. Jousset. Let me call your attention to the new edition, entirely rewritten, of the *Pratique de l'Homœopathie Simplifiée*, by Dr. Espanet, a manual the most complete, the most scientific, and, at the same time, the briefest that I know in the language. We have published in French the *Lectures, Clinical and Didactic, on Diseases of Women*, by Dr. Ludlam, which my friend, Dr. Dorion, of St. Paul, Minn., and myself have had the pleasure and honor to see through the press.

All this, my dear Dr. Winslow, is very incomplete, and gives you but an imperfect notion of the state of Homœopathy in France, and I am really ashamed to present such a defective sketch to the American Institute of Homœopathy. But the hour of departure presses, and I can only charge you to transmit my respectful homage to the learned assembly, and also to say that those sentiments of fraternal sympathy which have existed since the days of Washington and Lafayette shall forever live in the hearts of Americans and Frenchmen.

Votre tout devoué,

DR. ABEL CLAUDE,

Secrétaire général de la Société Medicale Homœopathique de France; ex-Chef de Clinique de l'Hôpital St. Jacques; Medecin de cette établissement; Membre correspondant de la British Homœopathic Society, etc.

18 RUE DE CAUMARTIN, PARIS, FRANCE, June 1st, 1880.

DR. BAER: I move the adoption of the recommendation of the chairman on the Committee on Foreign Correspondence.

DR. TALBOT: I second the motion.

The question being on the motion of Dr. Baer it was agreed to.

DR. TALBOT: I move that the correspondence be referred to the Committee on Publication.

THE PRESIDENT: That was intended to be included in it. The correspondence will be so referred.

DR. W. H. WINSLOW: I have received several papers from abroad; what will you do with them?

DR. ALLEN: I move that they be referred to the Committee on Publication.

THE PRESIDENT: It is moved that they be received and referred to the Committee of Publication. Are you ready for the question?

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The motion being seconded, and question being on the reception and referring of the report, it was agreed to.

DR. TALBOT: I move that the Bureau of Obstetrics be taken up.

THE PRESIDENT: The chairman of the Bureau of Obstetrics, Dr. O. B. Gause, is not present; Dr. George B. Peck, of Providence, R. I., will report the bureau.

GEORGE B. PECK, M.D.:

Mr. President, Ladies, and Gentlemen: It is a matter of profound regret with me that Dr. Gause was detained by personal infirmity from being here to-day to take charge of his department; especially because of the fact that I did not receive notice. I am the youngest member of the bureau; I did not receive notice that I must take charge of it until a week since. He wrote me to call there on my way to this place of meeting, and there he gave me the following message to the Institute.

It happens that but one member besides myself is present with papers. He wished me to state that the reason of the deficiency of the bureau was not altogether his personal infirmity, but because he felt grieved at the action of the society at its last meeting. He made me promise to make this statement. I feel it also due to certain members of the bureau who are here present, and who have papers and have presented them in other years, that the choice of the subject be left with them.

The bureau would present the following papers: Extra Uterine Fœtation, by C. Ormes, M.D., Jamestown, New York; a paper on Placenta Prævia, by George B. Peck, M.D., Providence, R. I.; The Forceps and the Principle of their Use,* by R. M. Foster, M.D., Chicago, Ill.; Improvements in the Science and Art of Obstetrics, by G. C. Walker, M.D., St. Louis, Mo.

The time having arrived for the adjournment of the Institute, it was adjourned to 3 P.M.

AFTERNOON SESSION.

THE PRESIDENT: The Institute will now please come to order. The Bureau of Obstetrics is the first thing in order, Dr. Peck, chairman.

The papers of Drs. Ormes and Peck were then read.

THE PRESIDENT: What will you do with the report of the Bureau of Obstetrics? The papers are open for discussion.

* Paper not received.—GENERAL SECRETARY.

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DR. TALBOT, of Boston: Might I be allowed a little time to present a matter of interest, especially to Professor Franklin, who is compelled to leave this evening? I move that Dr. McClelland be requested to exhibit and explain an improved jacket for the treatment of spinal curvature.

The question being on the motion of Dr. Talbot it was agreed to.

DR. J. H. MCCLELLAND, of Pittsburg, Pa.: This is a substitute for the plaster of Paris jacket. I have here a modification of a jacket first made by Dr. Vance, of Louisville, of paper and glue, used considerably by Dr. Breyfogle, and brought to my attention by Dr. S. C. Scott. This one is made of crinoline instead of paper, a suggestion of Dr. C. B. King, of Allegheny City, Pa.

The method is to apply a regular plaster bandage or jacket (by which you get the exact shape and form of the child), and then take it off as soon as it becomes hard, using it as a mould instead of leaving it on for two or three months, as the Sayre method is. Having made a plaster of Paris bust with this mould, representing the body of the patient with all its irregularities, you proceed upon this to build your jacket of such materials as paper or crinoline and glue. The first advantage of this is its lightness, and the second and greatest its removability. The most frightful ulcerations have occurred with the Sayre jacket because of its immovability. This can be taken off as often as necessary. Having removed it the child can be bathed and rubbed and the jacket replaced.

Where a jury-mast is necessary you build in your jury-mast the same as with the Sayre jacket, except that you take your time and build it on the cast with crinoline.

DR. BREYFOGLE: Do they wear it right over the undershirt?

DR. MCCLELLAND: It is worn right over the undershirt. You lace it up in front. I have had made under my immediate direction some eighteen of these within the last year, and they are a magnificent thing; a splendid improvement over the Sayre jacket. We all know, also, that Professor Franklin has an improvement on the Sayre jacket. In building this jacket I cover the plaster cast with wax paper to keep the materials from stick-

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ing. One trouble is that the moisture of the body will soften the glue. In order to obviate that trouble I have them varnished with shellac.

DR. SCHNEIDER: Why would not celluloid make a good jacket?

DR. MCCLELLAND: If you could build it on the bust it would amount to the same thing.

DR. SCHNEIDER: It could be built on the bust.

DR. FRANKLIN: There seems to be some little anxiety on the part of some members of the Institute to hear from us in reference to this matter. I suggest that this matter be taken up by the Surgical Bureau next year. I am not prepared to say that this is a substitute for the jacket which I use. If I had time I could prove that it does not act as a substitute for the jacket I employ. If the Institute will arrange so that the subject will come under discussion next year, I shall be very happy to show wherein I think that the jacket I have made is an improvement upon the Sayre jacket, and is superior to this jacket in many respects. I would take great pleasure in bringing casts and showing some patients that I have treated. I will show some who have been perfectly paralyzed, and not able to move the arm or either extremities. They are now walking about and doing ordinary chores, and this too in eight months.

THE PRESIDENT: The papers of the Bureau of Obstetrics are before you for discussion or otherwise.

On motion the bureau was closed. (See Appendix to Bureau Discussion.)

THE PRESIDENT: I appoint as chairman of this bureau for the next year Dr. George B. Peck, Providence, R. I.

THE CHAIRMAN: The next business in order is a presentation of the report and papers of the Bureau of Gynæcology, S. R. Beckwith, M.D., Cincinnati, Ohio, chairman.

THE SECRETARY: Dr. Biggar has consented to take charge of this bureau. I wish to make the *amende honorable* for the non-appearance of Dr. Biggar's name on the programme. It was due to carelessness in transcribing the names. I also have to apologize for the non-appearance of the name of Dr. E. M. Hale on this bureau. His name was on the manuscript, but by some

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unaccountable oversight in the proof-reading I did not notice its omission until many of the circulars had been sent out. I think this explanation due not only to Dr. Hale and Dr. Biggar, but to the chairman of the bureau, Dr. S. R. Beckwith, of Cincinnati.

DR. BIGGAR, Cleveland:

Mr. President, Ladies, and Gentlemen: I take charge of the bureau at the request of the chairman. There was a meeting of the Bureau of Gynæcology by section yesterday, in which a paper was read and discussed on the Lacerations of the Cervix Uteri. This I give into the hands of the American Institute to act their pleasure. In regard to priority, I think I should have said the subject for discussion selected by the chairman of the bureau was Pelvic Cellulitis from the beginning to the end,—the etiology, the prognosis, the diagnosis, the medical treatment, and the surgical treatment. Many of you are aware that Professor Beckwith has been quite ill, as the result of poisoning from the removal of an ovarian cyst, which has to a very great extent prevented him from turning out to work, as he intended, and in consequence of his sickness we have an imperfect report.

In regard to the subject selected, Pelvic Cellulitis, there are two gentlemen to whom were assigned the work who are here ready to report. In regard to these, Dr. Ludlam is ready to report on that which was assigned to him, The Prognosis of Pelvic Cellulitis.

Dr. O S. Runnels also is ready on the Etiology and Diagnosis of Pelvic Cellulitis, but it is the wish of the bureau that they be allowed to continue this subject the next year, and complete it in all its bearings. Perhaps this may be granted by the American Institute when it is known that we have some volunteer papers in regard to this, and also some members of the bureau who did not take that which was assigned them, but selected some topic perhaps more pleasant to themselves and more interesting to this meeting. We have a case of uterine fibroma, successfully removed, taking with it the uterus and both ovaries, by Dr. Ormes, of Jamestown, N. Y., occurring recently, within five or six weeks. He wishes to present his paper and read his report.

We have also another paper by Dr. E. M. Hale, of Chicago, entitled How do Medicines Act on Diseases?

We have another on Uterine Stem Pessaries, by Mrs. Dr. Cook, of Chicago. We have also a very interesting paper from Dr. Lungren, Toledo. Dr. Lungren has twice successfully performed the Cæsarean section upon the same patient. He wishes to report in regard to it.* We have also a paper by Dr. B. Frank Betts, of Philadelphia, entitled The Influence of Homœopathic Treatment upon the Development of Ovarian Cysts. These are all that are presented in the bureau. With the permission of the Institute I will first call upon Dr. Ormes to read his paper upon Uterine Fibroma.

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* Transferred to the Bureau of Obstetrics.—GENERAL SECRETARY.

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Paper read by Dr. Ormes.

DR. REUBEN LUDLAM, Chicago: I would like to suggest before it is forgotten, before they slam this bureau too, as they pretty often do in a sudden manner, that in the subsequent history of this case, after the operation, there was an interesting point which makes it certain, first, that the patient had no septicæmia because of the low temperature, and consequently she had no peritonitis because of the low pulse.

DR. BIGGAR: The next paper will be read by Dr. E. M. Hale, of Chicago. The title of the paper is How do Medicines Act on the Generative Organs of Women?

Paper read.

T. C. DUNCAN: I would like to inquire if there is a rule limiting the papers to fifteen minutes.

THE PRESIDENT: The Chair understands that there is such a rule.

DR. DUNCAN: I renew my inquiry, and say that if some of these papers were read by title it would be better for all concerned.

DR. BIGGAR: Mr. President, the next paper is entitled The Influence of Homœopathic Treatment upon the Development of Ovarian Cysts. It will be read by Dr. B. Frank Betts, of Philadelphia.

Paper read.

DR. BIGGAR: The next paper will be read by Dr. S. S. Lungren, Toledo, on Cæsarean Section.

Paper read.

DR. BIGGAR: The next paper will be by Mrs. Dr. Cook, of Chicago, on the Use of the Stem Pessaries.

Paper read.

DR. BIGGAR: That is all that this bureau has to bring before you; the papers are now all handed in.

DR. JENNEY, Kansas City: I move you that the bureau be closed.

DR. LUDLAM: I want to say before it is closed, I am very glad that Dr. Lungren tied the Fallopian tubes, because he might just as well as not have operated once more.

DR. BIGGAR: We have no objection, Mr. President, to the closing of the bureau, provision being made for the papers of

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Dr. Lungren and Dr. Runnels being read, that they be withheld until next year for the very reason that the subject assigned to the Gynæcological Bureau was dismembered, this being only part of the papers. I would be quite glad to finish the subjects next year.

Vice-President Hall in the chair.

THE VICE-PRESIDENT: Are there any further remarks upon these papers; if not the bureau will be closed and the papers referred.

The question being on the motion of Dr. Jenney, seconded by Dr. Morrill, to close the bureau and refer the papers, it was agreed to.

THE VICE-PRESIDENT: The chairman of the bureau for the coming season will be Dr. R. Ludlam, of Chicago.

On motion the Institute adjourned to meet on Friday morning at 9 o'clock.

FOURTH DAY.

CLOSING SESSION.

THE PRESIDENT: The Institute will please come to order.

DR. HALL, Chicago: Mr. President, I wish to offer a resolution. Many of the members, from the Western States at least, have found it very difficult to make arrangements with the railroad companies to get reduced rates. Inasmuch as our meeting will be in the Eastern division next year, and it will be much more important and probably will conduce much to the interest of the convention, to have a large delegation from the West, I desire to make some arrangements whereby we can secure railroad fares at reduced rates. I would say that the reason why we have not been successful is owing to the fact that in our large metropolitan centres there are combinations, and different railroads have pulled together in such a manner that the local agents at those points cannot make special rates to favor this convention. I know of a party intimately connected with railroad circles, a railroad man of influence, who will be able to make, outside of those large centres, arrangements whereby the whole profession may secure round-trip tickets at reduced rates, much

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below anything that we have had before, and thereby secure of course the benefit for the Institute. I offer the following resolution:

Resolved, That Professor C. H. Vilas, of Chicago, be appointed by this Institute a committee of one with power to make arrangements with the different railroad companies at reduced rates to those attending the Institute next year.

This resolution was seconded by Dr. Burgher.

Agreed to.

THE PRESIDENT: The next business in order will be the presentation of the report and papers of the Bureau of Pædology.

DR. HALL: There is a special order of business for this hour.

THE PRESIDENT: That bureau is not in order, because we have a special order assigned for this hour.

DR. HALL, Chicago: I move that the special order be changed to 10 o'clock.

DR. MCMANUS: 10 to 11, if you please; I have to go away at 11 o'clock.

DR. HALL: I do it for this reason: I think certainly it is due to Dr. McManus to give him an opportunity to give us his experience, and many of us, perhaps, will never be privileged to receive from his trembling lips the admonitions that may fall this day. I would be glad to hear him, and for this reason I am actuated in making this motion.

T. C. DUNCAN, M.D., Chicago: I second the motion.

The motion of Dr. Hall was agreed to.

THE PRESIDENT: The Bureau of Pædology has the floor, W. H. Jenney, M.D., Kansas City, Mo., chairman. You will listen to his report.

W. H. JENNEY, M.D.: Mr. President and Members of the Institute: I have the honor to present the following papers:

Acute Gastritis, Anatomical Characteristics, Causes, and Diagnosis, by W. Edmonds, M.D.

Prevention and Treatment of the same, by J. C. Sanders, M.D.

A paper by Mary A. B. Woods, M.D., on the Dietetic Rules to be Observed in the Treatment of Diseases of the Digestive Organs.

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The first paper will be on Acute Gastritis, Anatomical Characteristics, Causes, and Diagnosis, by W. Edmonds, M.D.

Paper read.

DR. JENNEY: The paper on the Treatment of Stomatitis is quite a long paper, with nothing in it excepting what can be found in the Materia Medica. I will refer that paper by title.

The next paper is by Dr. T. C. Duncan, M.D., entitled Thrush, Anatomical Characteristics, Causes, Diagnosis, and Treatment. Dr. Duncan will now read his paper.

Paper read.

DR. JENNEY: The next paper will be by Mary A. B. Woods, M.D.: Dietetic Rules to be Observed in the Treatment of Diseases of the Digestive Organs.

Paper read.

Dr. JENNEY: This, Mr. President, concludes the papers of this bureau. I move that the papers be received and referred to the Committee on Publication.

Motion sustained and agreed to.

THE PRESIDENT: The chair begs leave to announce the following invitation in behalf of General E. W. Hanks, who has in charge the Hospital for Disabled Volunteers and Soldiers:

I extend to you and your society the hospitalities of our institution.

Yours, most respectfully,

A. J. HARE,
Surgeon.

I beg leave to say that I was talking with Dr. Hare last evening, and he said that during any time in the day he would furnish carriages to as many as would go out and accept of their hospitality. He would like to be notified by telephone of the number to come out any time this afternoon.

DR. EDMONDS: I move that the invitation be accepted with thanks.

Agreed to.

DR. ALLEN, of Ann Arbor, Mich.: Mr. President: Am I in order to introduce a resolution? If so, I ask general consent to move this resolution; it is seconded by Dr. Talbot:

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In order to secure a thorough medical education for our members, and the social and professional standing so conducive to success, a reputable English scholarship is not only essential but absolutely necessary; therefore,

Resolved, That the members of this Institute be requested to demand the qualifications necessary to comply with the matriculation examinations of our colleges before the student enters upon his professional studies.

DR. T. C. DUNCAN, Chicago: I move that it be referred to the Bureau of Organization, Registration, and Statistics.

DR. F. R. MCMANUS, of Baltimore: I second the resolution.

DR. T. C. DUNCAN: Is that open for discussion?

THE PRESIDENT: That is open for discussion.

DR. ALLEN, of Ann Arbor: I wish to supplement this, Mr. President, by a few remarks. I do not wish this reference to the Bureau of Organization, Registration, and Statistics, or any other bureau, for the simple reason that a reference means putting it in the waste-basket. I think there is a necessity for the members of this Institute looking a little after their qualifications in gentlemen who are intended for the medical college. Any gentleman who has anything to do with a medical college knows full well that a great many students are sent to medical colleges who really cannot spell a word of three syllables. Now, for our satisfaction, for our success in practice, is it not necessary that we should take some steps in this matter? And you can do it, or we can do it, as members of this Institute. We can do what the college cannot do altogether, or so completely. If you will begin at the bottom, at the foot of the ladder, and see to every student who makes an application for membership, and you can see just as well as any one else. There are certain requirements necessary in order to enter the medical profession. The first is that the student should understand something of the English language. I do not say he should not understand Latin or Greek, or some other language. I should prefer, for my part, that a reputable English scholarship should be given as the groundwork, rather than a poor English and a smattering of Latin and Greek; then, when he goes to college, he is able to appreciate the instruction which he receives.

DR. DUDLEY: I move that this resolution be not referred. I am glad that this resolution has been offered, and hope that it will not be so disposed of that the Institute shall lose sight of it.

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I think it a very strange thing that our colleges, the one college that I am connected with included, should be so undecided in this matter as that a student may go to the college, may pay his money to the college, and afterwards be rejected and prevented from graduating on the grounds that ought to be known to the faculty before he entered. Such things have happened in the Philadelphia College, but it does not look to me to be quite honest, and I hope that, if this is referred to the Bureau of Organization, it will be with instructions to report positively.

Dr. Von Tagen, Chicago: Mr. President, Ladies, and Gentlemen: I believe the Cleveland College, at the time I was attached to it, was the first that issued a circular to encourage a graded course of lectures of four years. If I am incorrect I wish to be corrected. But I make that assertion here, and one of the principal features of that movement was to require students applying for entrance to the college to undergo a preliminary examination, and this examination was to be complied with before matriculating. That to encourage this movement a prize was offered for that purpose, and our circulars went forth all over the land. I think we distributed some six thousand on that occasion, and the movement received a start in that way, and I believe it would have succeeded had there been backbone enough in some of the members of the faculty to carry it out. It went through one year, and out of the class of some 90 students, I think we had that session, 47 came in under that requirement. It was left optional to the students at that time, although I was very desirous to make it obligatory, but I could not carry my point. I am glad now to see this subject agitated again, and I agree with the gentleman who objected to its going before this Bureau of Registration, for it will meet the fate predicted. I am therefore in favor of having it adopted and recognized, and put in force in fact. Let this Institution, this great American Institute of Homœopathy, be the one to push this matter through.

Dr. T. C. Duncan, Chicago: I withdraw my motion and move the previous question.

The Chair: The previous question is moved.

Dr. Beckwith: I wish that could be withdrawn for, I wish to make a few remarks.

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THE PRESIDENT: Dr. Beckwith is out of order. Shall the question now be put?

The question being put the Chair decided that two-thirds had voted in favor of the previous question.

The question is now on the resolution of Dr. Allen, which is not open for discussion.

The resolution of Dr. Allen was then adopted.

DR. EDMUNDS: I rise to perform a duty, which although it may seem commonplace on account of the frequency of its occurrence, yet I feel, sir, that there is a peculiar call for it at this time. I offer the following resolution:

Resolved, That the members of this Institute tender their hearty thanks to the retiring officers for their faithful discharge of duty.

The question being put by Dr. Ludlam it was unanimously agreed to.

DR. DAKE, of Nashville, Tenn:

Mr. President, Ladies, and Gentlemen: I wish on behalf of the Committee on the President's Address to report that upon careful consideration they cannot recommend a change in Sec. 1, Art. III, of the Constitution. The general review of the medical progress during the year is considered to be of permanent importance and of special interest to the members. They consider that sufficient. As for the first resolution adopted June 8th, 1854, they would approve of the recommendation of the President, that it be stricken from our records. They feel that in striking out the resolution the Institute would remove a very needless bone of contention. Some see too much and others not enough, so that none are entirely satisfied. Such a definition or statement of the creed can only lead to harm.

(Signed) DR J. P. DAKE, Nashville, Tenn.
DR JOHN W. DOWLING, New York,
DR. WILLIAM B. KENYON, Buffalo, N. Y.,
Committee.

DR. I. T. TALBOT, Boston: I move that the report be accepted and adopted.

The question was then stated by the Chair.

I. T. TALBOT, M.D., Boston: Before the motion is put allow me to say one word. I wish to say that there was another recommendation of the President which we deem of great importance. He recommended that in medical schools the examina-

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tions for the degree of Doctor in Medicine be conducted by censors, and not by their instructors. We heartily indorse the recommendation of the President, and hope the time will come when it will be carried out.

GEORGE A. HALL, M.D., Chicago, Ill., *Vice-President*, in the chair.

THE VICE-PRESIDENT: That you submit as part of the report.

DR. DAKE: We do.

THE VICE-PRESIDENT: You have heard the motion and heard the report; are you ready for the question?

Question was called for by several members.

DR. TALBOT: That is a question I think which should be discussed by those who are acquainted with the matter. I merely move the adoption of the report.

THE VICE-PRESIDENT: Professor Talbot, then, simply includes the written report, and not the verbal one, submitted by the chairman of the committee.

The question being on the motion to adopt the report of the committee it was agreed to.

THE VICE-PRESIDENT: The special order of business is now in order. I have the pleasure of introducing to you our venerable friend, Dr. F. R. McManus, of Baltimore.

DR. F. R. MCMANUS, of Baltimore: Mr. President, Ladies, and Gentlemen: I must first thank the members of this Institute for this privilege of an hour's conversation. I was assailed at Lake George on the subject of the dilution which I was in the habit of using in my medical practice, always for forty-three years, by being told that in all that period I had never given one dose of medicine. I considered it complimentary on the one hand but not on the other. I considered it complimentary, for the reason that I thought the Great Eternal had vouchsafed to my sugar of milk a wonderful power which he himself must have maintained.

I was asked to give at that time or at that meeting an address upon my experience of those forty-three years in homœopathy. I promised to do it provided the Institute would give me one solid hour. That was promised but never granted. I now ap-

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pear before you for the purpose of giving you in that hour, as near as I can, the important points in the history of my homœopathic career, or career in homœopathy.

In searching after the kernel of a nut we will all be of the opinion that it is first necessary to take off the bark, and I propose in exhibiting to you the kernel to begin by removing the bark. You will excuse me for having what may appear to be anything at all like an egotistical manner. Please remember that I am talking to you and giving you the reason of my faith, my hope, my practice, my success in homœopathy.

I graduated at the University of Maryland fifty-one years ago on the 6th of last April. I practiced medicine *secundum artem* for eight years and a half. At that time I began to congratulate myself and feel a little vain on the subject. I began to think that I was beginning to be an old doctor, and to possess about as much knowledge as other old doctors. I was getting after those eight years the fundamental principle as an allopathic doctor that I imbibed when I was a student in the University of Maryland. The old professor used to tell us in all cases where you meet with congestion bleed generally and locally; in all cases where you meet with deranged secretion give Calomel; and with those two general fundamental landmarks I proceeded for those eight years and a half. By some remarkable circumstance I was called early one Sunday morning to see a youth, fifteen years of age. The demand was responded to immediately; the boy was in convulsions and had been for two hours. I went to the house and found him totally insensible, with all the concomitants of that condition. He could say nothing, and I had only the external manifestations in the case to be governed by. With my fondness for the lancet I put a ligature on his arm and bled him eighteen or twenty ounces, which I thought pretty good for a beginning. I ordered cold applications to the head, and had him cupped in the cervical part of the spine, and purged by a powerful enema, and sinapisms to the extremities. I pursued that course for about twenty-four hours very faithfully, when the boy died. When I pronounced him incurable the mother said to me:

"Doctor, what do you think of homœopathic medicine in this case?"

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"Homœopathic medicine! why, there is nobody who practices it here, and it is only the shadow of a reality anyhow, and there is no medicine on the face of the earth that is going to cure your son, because he is in a dying state."

It was a sad thing for the mother, who was a widow. I attended the boy's funeral, and in the carriage with me were two persons: one was the minister, who had attended him spiritually, the other was his employer, a drygoods merchant. The minister, with whom I was well acquainted, said to me:

"Dr. McManus, I certainly think so far as your remedies were applied they were powerful, and according to the requirements of your system of practice. I think you did all that anybody could do, but really and truly, if you will excuse me for saying it, I think the boy was literally butchered."

We reached the graveyard, and the minister got out and walked with the corpse, or behind it. The merchant said:

"Dr. McManus, I think you are the most amiable young man I ever saw. Why," said he, "I wondered that you did not pitch that fellow out of the stage, to make such a charge as that, that the boy was murdered."

"Well," said I, "I know this gentleman well. He is distinguished by virtue of his erudition in literature and, I suppose, in all theological tenets, and like all other great men he is deluded on homœopathy."

The morning after the funeral he introduced the subject again, but I was very taciturn; I was afraid the drygoods merchant would find out the reverse of my being amiable, and so I thought I would say nothing. He said he had spoken to several physicians on the subject of homœopathy, but that they were so inveterately bound by prejudice that he did not believe there was a man in the medical profession in Baltimore who would be willing to investigate or who would dare to do it. I replied:

"My friend, you are very much mistaken. I would consider that the time consumed in the investigation of this thing was time lost. I have got no time to lose, but to show you that there is one man in the medical profession who is willing to investigate it, I will promise you, if I can obtain the means by which that investigation is to be accomplished, I will do it, and

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I will do it faithfully, and I will do it with as much fidelity as if I was starting on the road which led to heaven."

I made up my mind, having heard that there were several physicians in Philadelphia who were practicing homœopathy,—there was not one in Maryland,—I made up my mind to go to Philadelphia, and if I could find a gentleman who had been engaged in both practices I would talk to him. I heard of Dr. Marplac, a gentleman of the Society of Friends, who stood very high in the profession. I did not know where he lived; I had no direction by which to find him. I looked up the directory and I found there were two of that name. I called to see the one nearest to my hotel and I asked to see the doctor, and told him the business of my visit to Philadelphia. I said to him that I was from Baltimore, and gave him to understand the object of my visit.

"Why," he says, "it is very easy for you to ascertain all about that if you read such a number of the *Medico-Chirurgical Journal.*"

"Well," says I, "I have read that, and I agree with everything it says exactly; but I have started on a mission and I am going to accomplish it. Do you know this gentleman by your name?"

"Well, I did once, but I don't know him now."

I went to see the other gentleman and introduced myself, and stated my business, and asked him if he would feel at liberty to answer any questions in regard to the manner of my business.

He said: "Certainly and with pleasure."

Then I said to him: "Doctor, how long have you practiced medicine?"

"Twenty years."

"Did you practice the old system; if so, for how long?"

"For fifteen years."

"Then you have practiced homœopathy for five years?"

"Yes."

"May I ask you, on the start, did you prefer that as a mode of practice to the other?"

"Well," said he, "if I did not I would not practice it."

"Now," says I, "you must excuse me, and any question that

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I will ask you. But have you ever cured a case of inflammatory croup with it?"

"Yes, sir; dozens of them."

"Have you ever cured a case of unquestioned pneumonia?"

"Yes, sir; I cure them when they come up."

"Without any bleeding or depletion?"

"Yes, sir."

"You have cured pleurisy, have you?"

"Yes, sir."

Well I went on asking him with regard to a great many diseases that I knew would not be cured by the *vis medicatrix naturæ*.

He said to me: "Dr. McManus, you tell me you have been practicing medicine for eight years and a half?"

"Yes, sir;" I answered.

"Well," he says, "it is not worth while for thee to ask me any more questions, because thee could not believe me. If you are going to investigate this thing you will have to do it for yourself. I can tell thee of hundreds of cases that I have cured, but I don't expect you to believe me, because I would not believe you or any other man unless I had seen it. I would have to see to believe, and then at the beginning I must assure you of one fact, and that is, that I questioned the certainty of my own success. Do you understand German?"

"Not a word of it."

"Well, then, you cannot do the investigation justice. If you feel in the mind to undertake the task go home and employ a German teacher, and study the German language. There is not now one solitary English translation of any important work connected with your investigation."

"Well, what books would you advise me to commence with?"

He gave me a list of three or four books and said: "By the time you have finished these, and finished the translation of the first publication of Jahr's *Manual*, you will be prepared for others."

Having purchased them I returned to Baltimore, and employed a first-class German teacher. I am giving this history

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as a preliminary, because I want the members of the Institute to understand what some of us went through forty odd years ago in comparison with the little that they have to encounter in accomplishing the same facts. My teacher understood the German, but not the medical technicalities; I understood the medical technicalities and not the German, and between us we commenced the practice of homœopathy.

I would go around in the morning. I had some reputation as a very successful practitioner when I started out, and I did not want to lose that reputation, and above all things I did not want to lose a patient. Without any faith at all in the efficiency of the homœopathic remedy I commenced in this way, and I am sure you will all give me credit for the indefatigable way and manner in which I commenced the work and carried it out. I would take the patient's symptoms,—those cases I dared to trust, for I did not want to lose anybody,—I would take the required symptoms in the morning and I would meet my German aid in the afternoon, from 3 to 4. At 5 the persons were to send for the medicine I was going to prepare homœopathically. This gentleman and I worked together for three months, and now here is a singular circumstance connected with the whole thing.

He said to me: "Dr. McManus, you will have to get another teacher."

"I am sorry for that; why?"

"Well, I am going to study theology at the Lutheran College in Maryland."

"Can you recommend anybody else to me?"

"Yes, I will recommend to you a gentleman, a highly educated gentleman, and I will introduce him to you when I next call upon you."

I found him a very nice gentleman, but at the end of three months he said to me: "Dr. McManus, you will have to get another teacher."

"Well, why?"

"Why," said he, "I am just about to commence the study of theology."

Simultaneously with that, and unfortunately for me I have often thought, I dropped the study of the German. Then there

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came out a repertory of this first American translation of Jahr's *Manual;* then I was made up. I had not to go over these German books to find out what I wanted. I then commenced on my own hook without the German. I speak of this period with a great deal of pleasure for myself, because really if I had been told what I had to go through at the beginning of my career my courage would have failed.

Now I have removed the bark. The first case that presented itself, that I felt like using my remedies upon, was a case of orchitis. I must state that I purchased such medicine in Philadelphia, at the suggestion of Dr. Marplac, as he thought was necessary for me to have. I had Dr. Hering's *Domestic Physician* with his thirty or forty remedies, and his domestic book, and I purchased a box containing 117 medicines, which I supposed to have been prepared in Leipsic. It was an ever-memorable box, as you will find out after awhile. This case of orchitis was the result of gonorrhœa treated by mechanical means—injections. The person who applied was a married man, which made the thing a great deal worse, and he could not very well rest from the necessity of his business. His case was almost too frightful for an experiment of this kind. However, I made up my mind to try Arnica with him, and I gave him three powders of Arnica and something to follow each successive day that would not conflict with the Arnica or anything else. I told him to take a powder half an hour after every meal and then to come to me, and if he should be worse to come to me immediately, or to stay at home and go to bed, and remain in bed and send for me, and I would immediately come to see him and do something for him, and give him something which would be perhaps more suitable for the case. The gentleman was as good as his word. This man was a cooper by trade. I did not want to tell him to lay in bed while taking the powders; that would have been better. Rest would be a powerful adjuvant in his recovery if he got well, and be laid to that, so I said to him (you all know the duties of a cooper, its very urgency and arduousness; the man had to work around in hooping the barrels): Go on with your work, unless you get worse, and then go home and go to bed and send for me." That man came to me again the third day.

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"Well," said I, "how are you?"

He said: "Doctor, I think I am well."

"Do you think you are well? that cannot be possible."

Well, you can imagine how I felt about the thing; there was nothing given to him on the face of the earth but that Arnica, and that was of the 30th attenuation for all that I knew. Nothing else known to us at that time. Well, I did not know exactly what to do. I thought that the man was very nearly well, and I found that upon examination there was a normal reduction of the diseased parts, and a restoration to its normal size, and nothing left but a little redness. So I repeated, not the Arnica, but the other six powders for two days, for the simple reason that I did not know which was better to do. I had read what I considered the wonderful weakness, on our part, of the distinguished Hahnemann in having given antidotes. I said, Is it possible that this case needs an antidote—it is possible I have given him a little too much in these three doses of Arnica—if these three doses of arnica have produced this effect? I want to be satisfied any way, and so I will wait. These six powders finished him, and I tell you that in my own sober senses and in the presence of the Great Eternal, I am often disposed to ask myself the question, is this a fact or is it not?

Two or three days afterwards I was passing the house of an old country squire. He always greeted me with a polite salutation:

"How are you, doctor?"

And I would reply: "Very well, how are you and the family?"

He replied: "Mrs. Sterling is not very well. She suffers with a pain in the knee."

I had treated Mrs. Sterling for a pain in the knee, but I had not cured it; I had done everything for her that my extended practice in my old way would suggest, and gave the case up. Well, I thought, as a curiosity, that I would try if I could find anything in this homœopathic box that would apply to that case, and if I did that I would try it. After an untiring search I thought perhaps Pulsatilla would cure her. I called with the Pulsatilla, and I told the lady "that I had just placed into my hand a new system of medicine; I did not know exactly what it

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was going to do. I was trying it, and as long as I would guarantee it would not hurt her at all I would try the experiment."

She said: "Doctor, I wish you could cure that knee."

I told her: "I wished I could, too."

As I told you before, I had tried everything on that knee—ointments, liniments, plasters, sinapisms, embrocations, and all that kind of thing. Well, I prepared two doses of Pulsatilla, and four powders which I thought suitable—they were not Pulsatilla. The Pulsatilla was marked one; she was to take one after every meal. I put one on her tongue, and she was to take the other after the next meal.

I forgot the case entirely, I had so much to think about. My mind was in so much excitement that I forgot all about the old lady. Five or six weeks afterwards I was passing the house, and the squire was standing at the door, and he said:

"How do you do, doctor?"

"Thank you," I replied, "I am very well."

Said he: "Do you recollect that you gave to Mrs. Sterling some powders some time ago?"

"Yes, I recollect that."

"Well," said he, "was it medicine?"

"Well," says I, "I gave it for medicine."

"Well now," says he, "I have been very anxious to see you, and I was going to call on you."

Two or three days afterwards Mrs. Sterling found, to her surprise and delight, that she had lost the pain in her knee, and was able to walk as well as ever she could. She had taken the whole of the six powders, and I suppose she concluded that the last two were the effective ones.

However, that was another case. That was Pulsatilla of the 30th attenuation. At least it was sold to me for that, and I had no means of ascertaining whether it was the 30th or the 30,000th. These are two cases. At that time that was the view that I had. That was the way I commenced, gentlemen; I had very few books, and I had to work my way along. I had a very singular case some time after this. I saw an announcement in a paper of a homœopathic physician by the name of Dr. Radcliff, and at that time I had a very singular case, and I did not know what

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to do with it. It was a case that I defined to be neuralgia, rheumatic pain, or rheumatism. The neuralgia was intermittent neuralgia. The lady was 19 years of age, very sensitive in her organization and in her nervous system. Every day at 2 o'clock, after an intermission of six weeks, she was taken with what she called a needle pain. She felt as if a needle was stuck into her heart, and that was immediately followed by a convulsion which lasted from thirty minutes to two or three hours. I commenced the treatment of the case on the tonic plan; I commenced with the Sulphate of quinine, which I gave for this difficulty. Still the pain came on at two o'clock. I gave the medicine faithfully for two or three days, but it had no result. Then I resorted to a preparation of Arnica flowers and a solution. Finally I anticipated the paroxysm by sinapisms anteriorly and posteriorly. These were applied to the heart. I thought by the time we began to irritate the surface it would produce some effect; this was on the plan of counter-irritation. I thought by this plan that I might break up the paroxysms; I had never failed before. The fact was I did not know what to do. I saw this advertisement in the paper, and I said to myself, I do not know this Dr. Radcliff; nobody can tell me who he is; I will go and see him. I went to see Dr. Radcliff, and I told him the object of my visit. I did not intend to invite him to see the patient, because I did not know what kind of undercurrent influence might be exerted, and I was suspicious, because I did not want to be humbugged, and I did not want to humbug anybody. I related this case to him as I am telling you about it now. I said to him, "Did you ever treat a case of this kind?"

He said: "No, sir." He was a very intelligent man and very agreeable in his presence, bearing, and conversation.

"You never saw a case of the kind I suppose, and never had anything to do with it."

He listened to my story patiently, and after hearing me he said: "Doctor, I think a dose of Spigelia, the 30th, will cure that case."

I looked at the man, because I told him what I had been doing for six weeks. He considered it very powerful.

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"A dose of Spigelia," said I, "you do not mean the Maryland pink-root?"

"Yes," he said, "I will give you a dose."

"Well, what will I do with it?" It was then ten o'clock in the morning. "What will I do with it?" said I.

His reply was: "You put this powder on the tongue of the patient."

I saw him pour out the pellets in a little sugar of milk. I had the curiosity to take up the bottle; it bore the mark "Spigelia[30]." I left the house, and I thought to myself that man must be a fool, and yet he told it to me with that kind of assurance that would baffle everything like suspicion. I thought to myself if this dose of Spigelia will cure her I will try it. I went to see the young lady about ten o'clock, and I put that powder of Spigelia on the end of her tongue. I thought to myself it was a real piece of folly, but I told her I would come again in the afternoon. I was very busy, but I told her I would come to the house about 5 o'clock that afternoon. Now you must recollect that this patient had not missed a paroxysm for six weeks. Her mother met me at the door. She was standing on the portico, and she raised her hand and said: "Mary missed her pain to-day."

"Missed her pain. Had she any spasm?"

"Not at all; come in."

Well, I went in. The girl was sitting up. The first thing I did after feeling this astonishment was to feel her pulse. I felt her pulse carefully, and I asked her to put out her tongue, which she did very kindly.

"Well, Mary," said I, "how do you feel?"

She answered: "I feel better than I did for a long time; I think it is because I missed this pain."

I asked her: "Had you no symptom of it?"

"No," she said, "I never had any premonition at all, until it came like a needle sticking in my heart. But to-day I had nothing of it."

I looked at the girl, and I looked at myself, and I looked at the house, and I looked at the walls. Well, what conclusion am I to come to here, said I to myself? This must be the effect of

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the Spigelia. I told Dr. Radcliff that I would call and report to him that night. Well, I did not know what to report, as I had told the doctor if he could cure that case that I should be an unquestioned believer in homœopathy. I did not tell him that I was dabbling in the system myself at that time. I told him I only wanted to inquire into it. Well, I did not go that night. I thought I would wait until to-morrow, and when the morrow came I went at 5 o'clock in the afternoon to see the girl, and she felt remarkably well. I thought to myself that I must go to-night to see the doctor. So that night I went to see the doctor. He said to me, "You did not come to see me last night." "No," said I, "I was busy,—I was very busy,—I told you the truth, but really, doctor, I would wait and give the medicine all the time I could, because I did not want to hurry the thing."

"Well," he says, "did that powder have any effect upon that young woman?"

Then I said: "Really, I don't know how to answer that question." You see I was very careful about compromising myself.

"Well," said I,—I will tell you just exactly what I told him, —"I called at 4 or 5 o'clock in the afternoon, and the girl had neither pain, spasm, nor convulsion, and I called to see her again this afternoon and she had neither one nor the other."

"Well, sir," said he, "you told me that if I would cure that case, and I have cured it with one dose of medicine, that you would believe in homœopathy."

"Well, doctor, if I tell you now that I do believe you would say that I was a very visionary man, and I should think so myself. It is a powerful circumstance. It is a strong thing to have occurred, I will admit that, but it is a thing that has occurred. I did not expect and would not believe, if I had not seen it, the testimony of every doctor in the city of Baltimore. But I saw it; but the stumbling-block to me is how that one dose would cure that girl, after I had done so much that would not be considered inefficient. That is what I consider to be a very efficient and powerful remedy. But how that one dose could do it."

"Well," he says, "that's not astonishing at all, my friend. I

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think that is a very reasonable cure. But," says he, "do you know the reason?"

"Well," I replied, "I would like you to explain it if you please."

He responded: "The dose of Spigelia I gave was what the girl's case required, and what you did amounted to nothing, if not less than nothing." Then he went on in a very jocular way, enjoying, of course, my being so confounded about the case.

Well, I may as well stop with that case. Well, about the next case that came under my observation. I was sent for by a family, not far from my office, that I had been treating homœopathically as well as I could. The lady sent a servant to ask me to send some powders for the baby. The servant said it had a most distracting colic. Well, I made up my mind that perhaps Colocynth would cure it, and I sent her three or four powders. After awhile a boy came back and said to me that the child was going into spasms, and asked me if I would go immediately and see it. I went to see the child. "Well," said I, "Madam, I have seen many a case of colic, but I never saw anything of this character or heard anything of the character of this child's screaming." They were really the most distressing that I ever heard, and I said: "I shall conclude that this is not a case of colic." However, I turned the child upon its abdomen, on the palm of my hand, and held it that way, and every motion made the child worse. It occurred to me that nothing would quiet it. "Well," said I, "I wish you would examine this child, and take off everything that is on it, and look for a needle or a pin." Well, everything was taken off; the poor little thing was screaming at the top of its voice. We could not find any appearance of a pin, and I thought to myself, now I will make a kind of exploration upon my pathological knowledge, and I commenced examining the child, touching I suppose every square inch of the body that I could, but it was no use to depend upon that. The child's screaming continued. I could not find out anything in that way; but I examined the spine, passing my fingers along the spinal column. The child was still screaming all the time. I could not perceive any difference. Then I went to the right of the spinal column, in the region of the kidneys, and when I touched the kidneys the

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child jumped, and I thought nothing would hold it. I said to the lady: "Madam, I think that this disease is in the kidneys;" for every time I would touch that spot, and I tried it two or three times, the child would jump. Then I put up six or eight pellets of Cantharides the 30th, dissolved in as many teaspoonfuls of water. I said to her: "Give this child a teaspoonful every half hour. I will be in my office for two hours, and if the child is not better send me word, for it cannot go on in this way." Well, she gave a spoonful, and she gave another, and she gave another, and I heard nothing from the child. Of course, I thought, perhaps it might be a little better, because she was enjoined that she should send me word if it was not any better. In the evening, when I got over my round of visits, I found a call to go to that house immediately. Well, I wondered to myself, what am I to do? I went to the house, and the mother almost embraced me.

She said: "Oh, doctor, I am glad you have come; I don't know what to make of my poor child."

"Well," says I, "is there anything new?"

"Yes," says she, "I thought perhaps the medicine might be too strong for it."

I asked: "Why?"

Then she replied: "I only gave three doses, and the little thing went to sleep, and it has been asleep ever since, and I was afraid to wake it until you came."

Three teaspoonfuls of Cantharides the 30th, in solution. Well I said to her: "I will come in here again to-night at about 9 o'clock; don't disturb the child at all." You will think it is a fabulous thing when I tell you that the child awoke, had taken the breast, and needed no further medication.

Dr. Pearson, Washington: I just wanted to ask you; you said you gave Cantharides for colic?

Dr. McManus, resuming: The way I found that out was by the pathology, and I ventured on the Cantharides. I did not know what else to do. I knew it was recommended by Hahnemann for inflammation of the kidneys, and I followed the old man's advice. It is impossible for me to mention the numerous cases that I have had with the same kind of success. One day,

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after I was practicing for a year, I found out why it was that Hahnemann had recommended antidotes to the too frequent administration of some medicines. I was then getting a little bit complacent about my knowledge of homœopathy, although I did not know anything about it at that time. I don't know much about it now. One Sunday I had been attending an old lady afflicted with headaches and spasms, and I happened to be looking over Veratrum album, and I thought to myself this Veratrum is a wonderful thing. It is really a wonderful thing, and I wondered if that would not suit her case; and I said to myself when she comes again I will give her a couple of doses of Veratrum anyhow. So Sunday morning I gave her a couple of doses of Veratrum to take, two hours apart. When I saw her the next day I went to meet an allopathic physician, a full graduate. He said to me: "I want you to see a lady they call Sal Taylor. I wish you would go and see her in consultation." So I went to see Sal Taylor. It was Sunday morning; the people were going to church. I did not know exactly what to do for Sal Taylor, so I thought that case is very much like this other case of mine; I think I will recommend her to take three doses, two hours apart, of Veratrum. The doctor who was attending her was a very nice young fellow anyhow, and a fool at that. I thought I would try it anyway, and so I gave it to her, and about 4 o'clock in the afternoon I got a message from the doctor saying: "I wish you would come without delay and see Sal Taylor. She is deaf, blind, and dumb." I sent word I would come over as soon as I could. I also got a message from my other patient.

A gentleman came and said: "I am very much concerned about my wife."

Says I: "What is the matter now?"

"Well," he said, "I am in the very greatest way; the very greatest way, indeed."

"Well," said I, "what is the matter?"

He replied: "She cannot see out of one of her eyes, and she cannot hear out of one of her ears."

That was the 30th of Veratrum. I did not know what else to attribute it to. The coincidence was so great that it began to create in my mind a suspicion. So I went to see Sal Taylor.

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I felt of her pulse, and I said to her: "Mrs. Taylor, how do you feel?"

The doctor, who was there, said: "It is no use asking her any questions; she can't speak, she can't hear, and she cannot see; I have been here some time and I have found that out."

"Well," said I, "I think that I can cure her." So I gave her the antidote for Veratrum. I thought to myself I do not know anything else to give, and as it is evident that she is suffering from the effects of the Veratrum, I will give her the antidote. So I said to the doctor: "I think that this is a medicinal aggravation. I am not sure, but I think it must be."

Said he: "Dr. McManus, I always thought that you had common-sense, but now I think you are one of the biggest fools I ever saw. Those three powders could not produce this thing; as for me, I give it up. You may give what you please."

"Well," said I, "I am going to give her the antidote for Veratrum." And I put up two doses of the 30th of Mercurius viv. The mother was directed to put one on her tongue, and to give the other after two hours if she was no better. The next morning I called again. The doctor got there before me.

"Well, really," he said, "you were not such a fool as I thought," and he burst out laughing.

Says I: "What are you laughing about? how is the patient?"

"Well," says he, "I think she must be hearty. She can talk plain enough now; she answered all my questions, and she says she can hear everything I say."

I asked for the history, and her mother said that one hour after she put that first powder on her tongue, the girl was laying in bed beside her, she rose up, and her mother spoke to her, and said: "My dear, what is the matter?"

"Didn't you hear that pistol?" she asked.

"Oh! no," the mother replied, "I did not hear anything."

"Why," she said, "I just felt as if a pistol had been fired from one ear to the other."

After that she could hear, she could speak, and she could see. I tried the same experiment with the other patient and it was confirmed.

So I went on in that way, and I tell you I began to think I

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was getting on splendidly. But I said to myself, I must not trifle with this Leipsic box; and so I was more careful in my prescribing. I did not want to make the people deaf and dumb and all that kind of thing, you know. So I wrote a letter and sent it off to Germany, telling a friend of mine about my experience in this case; and he says you give too many doses, and perhaps you don't give the right thing; you have not got experience enough, and I will send you some other attenuations from the 6th to the 12th, and then there is not so much danger in repeating the dose. You can give more doses, and there will not be so much danger. The Leipsic 30th is dangerous. So I laid by that Leipsic box, and substituted the other, and went on in that way. So occasionally, when I dared to do it, I would give a very few pellets out of the Leipsic box. But I began to think that there was a wonderful difference. So, gentlemen, I could go on for hours and tell you of many cases, and perhaps instruct some of the younger members of the profession.

But I found out very early in my practice, when I became a real believer in homœopathy, that it would not do to repeat the dose. Now when I read the records of cases in the medical journals I read the cases very carefully, and I was looking over the *Hahnemannian*, of Philadelphia, on my way to this place, and was reading of a case where a gentleman was attending a case of incipient pregnancy. This case was accompanied by the most constant nausea and vomiting, and all its concomitants. He attended the lady for ten days, and in the ten days he gave her ten different remedies. On the third day he gave her the remedy that he ought to have given her the first day. Then he ought to have stopped; but being unsuccessful he considered it a case for further medicine, and sought to relieve the patient in that way. I was perfectly horrified to hear and read of cases of that kind. For example, I read of a case where a person is attending a child with the croup, or some other disease, especially acute diseases; and the doctor will say I ordered Aconitum and Belladonna and Spongia every fifteen minutes, and then I added to the three Bromide of potash. Well, I said to myself, my heavens! what does the doctor expect? to go on in that way, giving a dose of Aconite the 30th, and all these other things, when one dose

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would have cured the case—which ever was the remedy. And then as to that alternation, it only convinced me that they don't understand the business. They first take one medicine, No. 1, and then give No. 2, and then apply No. 3, and then No. 4, and if that don't do any good they will give No. 3 again. That goes to show a thorough want of confidence of the man in himself. If No. 1 is the remedy they don't want 2, 3, and 4. If No. 3 is the remedy they don't want 1, 2, and 4. This repetition of doses causes me to believe that the greatest enemy that the homœopathic physicians have is to be found in themselves. (Applause.)

They will give a man, for example, a dose of medicine at 9 o'clock, it may be Aconite, and then go to see the man at 10 o'clock, and think, well, I ought to give Bryonia, this patient has some of the symptoms of Bryonia. All I have got to say about that man is that he can never be trusted with acute cases. He never can trust himself, and I never would trust him. If I was sick myself I would not send for him; I would rather have a sensible allopath who knew what he was doing. That is the great secret. Then, perhaps, he would begin with the 30th, and having no better success would prescribe something else,—give some other remedy. That man, I say, is a fool who attempts to use the medicine in that way. Take, for instance, the vaccine virus. A man who puts it in the child's arm every morning and night for five days is a fool; that you will all agree with me, and say he must wait until the fifth day to see the effect. He must not vaccinate every day. That compares exactly with the modern practice of homœopathy. I am not personal, gentlemen, because I don't know who practices high or low, or who gives one dose a day, or one a week, or one a month. But there is one thing I have noticed in all the reports of cases that I read, that the low dilutionists—as I may call them, and I am very glad that they do, that it is a fortunate thing that they use the low dilutions—will give ten or twenty doses of medicines to one that would be given by my distinguished friend Dr. Lippe. In many diseases one solitary dose, well selected, will do the work; that is what Hahnemann says. That is the Hahne-

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mann theory, and that is the Hahnemann practice, and it must be followed by success.

Gentlemen, I could go on and tell you about these things for weeks, but I have said enough to satisfy you that I have been sustained in practicing with the 30th attenuation for forty-three years. I have never found it wanting. When I do I shall go higher or I shall go lower. As a member of the Bureau of the Board of Censors we have finished our work for this session. I am to leave at 1 o'clock. To the members present I may say in safety that nine-tenths of you I will never see again; but as long as I can give to each one a kind word I will say to you, with all the affection of my heart, I thank you for your kindness to-day and I thank you for your courtesy always. I wish for you from the Eternal Regulator all the happiness that this world can afford you in time, and in eternity. (Applause.)

Upon the conclusion of Dr. McManus's address, DR. J. P. DAKE, of Tennessee, said: Mr. President: I desire to occupy about three minutes to corroborate the statements of my worthy friend, and to supplement the proofs in his behalf.

At Lake George, last year, when he declared he was in the habit of using the 30th attenuation of drugs in his practice, he says an associate replied: "Then you have given no medicine these forty years."

I desire to testify that Dr. McManus has given medicine not so exceedingly attenuated as to make him liable to the charge of having given none at all by the recital of a little history.

Just twenty-six years ago, when the Institute held its session in the city of Albany, a little controversy sprung up regarding adjuvants and the use of medicines not pointed out by the homœopathic law. In that day I was so strict a Hahnemannian, I stood up so straight, I actually leaned over *backwards*. Drs. Wm. E. Payne, G. W. Swazey, S. R. Kirby, and myself were contending against Drs. J. H. Pulte, Samuel Gregg, and Lyman Clary, who were the advocates of liberal medicine, or, rather, of occasional resort to adjuvants and palliatives.

Dr. McManus, to show his position, related a case as follows:

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A child, suffering with membranous croup, had received no apparent benefits from the medicines administered, and was *in articulo mortis*, when he remembered favorable reports regarding the use of *lamp oil* (whale oil) in similar cases. Obtaining some of the oil, he straightway administered teaspoonful doses to his little patient with the happiest results. Recovery followed.

I hope the accuser of Dr. McManus, believing that there is no medicine in the thirtieth attenuation, will notice that the doctor has gone below that, actually curing with the crude drug what had resisted his attenuations, and that he will at once withdraw his charge that our venerable friend has administered *no medicine* in the last forty years.

DR. PRATT, of Illinois: As quite a large number of members are going to leave at 1 o'clock, I will introduce this resolution, which I will read:

Resolved, That a vote of thanks is hereby tendered to the Wisconsin State Medical Society for the very efficient manner in which its Committee of Arrangements has provided for carrying out the objects of the Institute, and to the individual physicians who have made personal sacrifices attended with considerable expense. They have made our stay pleasant, and our visit here interesting; it will long be remembered with pleasant recollections.

Seconded, and carried by acclamation.

I. T. TALBOT, M.D., of Boston: In connection with this, I move you, sir, that the Committee of Arrangements have full power to settle such small bills as the Institute may have incurred, particularly in relation to the hall and certain papers—*The Sentinel*—which have been left here for the benefit of the members.

Agreed to.

THE PRESIDENT: The next business in order is the presentation of the report and papers of the Bureau of Ophthalmology, Otology, and Laryngology, F. H. Boynton, M.D., New York, chairman. In the absence of Dr. Boynton, Dr. David J. McGuire, Detroit, Mich., will make the report.

DR. MCGUIRE: Mr. President: I have had left in my hands three papers—one paper entitled Ptosis, Diseases of the Lids, one on Ophthalmia, and one on Ectropion. These papers I beg leave to refer to the Committee of Publication.

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On motion, the bureau was closed and the papers referred.

THE PRESIDENT: The chairman of the Bureau of Ophthalmology, Otology, and Laryngology is Dr. G. C. McDermott, Cincinnati, O. The next business in order will be the presentation of the report and papers of the Bureau of Surgery, N. Schneider, M.D., Cleveland O., chairman.

DR. SCHNEIDER: Mr. President: This bureau chose for the subject this year the Diseases of the Alimentary Canal and Accessory Organs. The chairman of the bureau has corresponded with every member of the committee, and has assigned to them subjects, and has received reports from most of them, and would hereby present them. We have a paper from Professor Talbot on Staphyloraphy.

Dr. Talbot then read his paper, and asked that it be referred to the Committee of Publication.

DR. SCHNEIDER: The next paper is one upon Hernia, by Dr. J. H. McClelland, Pittsburg, Pa.

Paper read.

DR. SCHNEIDER: The next paper this bureau presents is one by Charles M. Thomas, M.D., Philadelphia. This article is on the Radical Cure of Hernia. It is an exceedingly valuable paper.

On motion, the paper was referred to the Committee of Publication.

DR. SCHNEIDER: The next paper that the bureau presents is one by John C. Miner, M.D., of New York. The subject of this paper is Acute Peritonitis in its Relations to the Diagnosis and Surgical Treatment of Diseases of the Abdominal Viscera. This is also an excellent paper, and quite a lengthy one; it should be carefully studied. This we will also refer.

The next paper that the bureau presents is one by Professor E. C. Franklin, on Polyps and Foreign Growths of the Rectum. This paper needs no comment, as you are well acquainted with the writings of this distinguished gentleman. I will also refer that paper.

The next paper that we present is one by Professor Hall, of Chicago, on Sphincterismus. This paper I would ask your indulgence to listen to.

The paper was then read.

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DR. SCHNEIDER: The next paper is one by Professor Hartshorn, of Cincinnati, on Injuries to the Abdomen.

Dr. Hartshorn read his paper.

DR. SCHNEIDER: The next paper we present is by Dr. L. H. Willard, of Allegheny City.

Dr. Willard then read his paper, and illustrated it with a chart.

DR. TALBOT: As chairman of the Bureau of Statistics, I request the privilege of making a final report of the bureau of Organization, Registration, and Statistics, as I am obliged to leave. It is enough simply to say that the bureau has received some additional statistics. We will report about 72 delegates here who have made a representation for their different associations. That there have been present at this meeting two hundred and two members. I move that the additional statistics and the report of the bureau be referred to the Committee of Publication.

Agreed to.

DR. DAKE: I wish to take the privilege of offering a resolution for Professor Smith. He is here now, and he wishes to leave, and will not have time again.

J. EDWARDS SMITH, M.D.: I will not detain you, but my resolution is for the interest of all; it is as follows:

Resolved, That any bureau is hereby authorized to appoint as an associate any homœopathic physician, not a member of the Institute, who may be distinguished in the department of which said bureau treats.

I would further state that I wish to secure on my Bureau of Microscopy a gentleman who is eminently distinguished as a professor of histology in the Philadelphia College.

DR. DAKE: He is not a member.

THE PRESIDENT: The Chair is of the opinion that the resolution is not in order.

DR. SMITH: Do I understand that the ruling of the Chair will prevent any person not a member of the Institute from reading a paper before the Institute.

THE PRESIDENT: These papers can be brought here, and by the consent of the Institute at any time received and read. The Institute can by its own action take any general action it pleases;

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but your resolution is entirely out of order. The Chair will not entertain a general motion of that sort. It will not prevent parties outside doing all the work they choose. They can present papers, and the Institute at that time can say whether they will receive the papers or not. The Bureau of Surgery still has the floor.

DR. SCHNEIDER: The next paper we have to present is one of my own, and instead of reading it I would beg the privilege of referring it. The title of the paper is Acute Intussusception. There are several papers that I expected here till the last moment, one from Professor S. R. Beckwith, Cincinnati, and one from W. L. Vincent. They were to have been sent by express; I would take the privilege, if I get them in time, of referring them to the Secretary.

On motion the chairman was given the privilege of accepting the papers.

DR. SCHNEIDER: This completes our report, and I would beg leave to say that the Bureau of Surgery was a little disappointed this year, as we had some very important papers, and it is getting now rather a late hour in the session. We have been pressed for time, and the discussions are necessarily lost to the society. I trust that hereafter the chair of Surgery will make arrangements for this matter.

On motion of Dr. Allen the remaining papers were received and referred, and the bureau closed.

THE PRESIDENT: The chairman of this bureau for the next year will be Dr. H. F. Biggar, Cleveland, O.

THE PRESIDENT: The next business in order is the presentation of the report of the Committee on Legislation, T. S. Verdi, M.D., Washington, D. C., chairman.

No report.

THE PRESIDENT: The chairman for the next year on Medical Literature, will be Dr. Pemberton Dudley, of Philadelphia. As there is no report from the Committee of Legislation that order of business will be passed.

The next thing in order is the report of the Intercollegiate Committee, J. D. Buck, M.D., Cincinnati, O., chairman. Is there any report from that committee?

THE SECRETARY: There is no report.

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THE PRESIDENT: There is no report, and that business will be passed.

THE PRESIDENT: John R. Kippex, M.D., Chicago, Ill., will be chairman of the Committee on Legislation, and I. T. Talbot, M.D., Boston, Mass., chairman of the Intercollegiate Committee for the coming year.

There being no unfinished business, or new business, upon motion of R. F. Baker, M.D., the thirty-third session of the Institute of Homœopathy was adjourned.

COMPLETE REPORT OF THE BOARD OF CENSORS.

ALLEN, CHARLES, M.D., Washington, D. C., . . .	Med. Dep. Georgetown Univ., D.C., 1861.
ARMSTRONG, WILLIAM P., M.D., Lafayette, Ind., .	Hom. Hosp. Coll., Cleveland, 1866.
BASSETT, JOHN S., M.D., New York City, ...	Berkshire Med. Coll., Mass., 1850.
BOARDMAN, HORACE E., M.D., Monroe, Wis., . .	Hah. Med. Coll., Chicago, Ill., 1867.
BROWN, GEORGE W. I., M.D., Dixon, Ill., ...	Hah. Med. Coll., Chicago, Ill., 1878.
CAINE, WM. H., M.D., Stillwater, Minn., ...	Hah. Med. Coll , Chicago, Ill., 1867.
CLARK, EDGAR W., M.D., Neenah, Wis., ...	Hah. Med. Coll., Chicago, Ill., 1868.
DALE, HARVEY B., M.D., Oshkosh, Wis., ...	Hom. Hosp. Coll., Cleveland, Ohio, 1860.
DENNINGER, PAUL G., M.D., Spring Valley, Minn.,	Hah. Med. Coll., Chicago, Ill., 1879.
DONALDSON, SAMUEL J., M.D., Portsmouth, N. H.,	Jefferson Med. Coll., Phila., Pa., 1870.
EATON, MORTON MONROE, M.D., Cincinnati, Ohio,	Rush Med. Coll., Chicago, Ill., 1861.
FOSTER, RICHARD N., M.D., Chicago, Ill., ...	Hah. Med. Coll., Chicago, Ill., 1869.
FRENCH, BENJAMIN F., M.D., Indianapolis, Ind., .	Hah. Med. Coll., Philadelphia, Pa., 1880.
GENTRY, WILLIAM D., M.D., Wyandotte, Kan., .	Hom. Med. Coll. of Mo., St. Louis, 1880.
GIVEN, ADAM, M.D., Louisville, Ky., ...	Chicago Hom. Coll., Ill., 1864.
HEATH, JAMES DE WITT, Shawano, Wis., ...	Hah. Med. Coll., Chicago, Ill., 1879.
HOFMANN, CHARLES H., M.D., Pittsburg, Pa., . .	Pulte Med. Coll., Ohio, 1878. N. Y. Hom. Med. Coll., 1879.
HUTCHISON, ADELE S., M.D., Minneapolis, Minn.,	Boston Univ. School of Med., Mass., 1877.
KENYON, CLAUDIUS B., M.D., Rock Island, Ill., . .	Chicago Hom. Coll., Ill., 1878.
LEWIS, JOSEPH, JR., M.D., Milwaukee, Wis., . . .	Hah. Med. Coll., Chicago, Ill., 1875.
MANNING, CAROLINE E., M.D., Chicago, Ill., . . .	N. Y. Hom. Coll. and Hosp. for Women, New York, 1876.
MAXON, JOSEPH S., M.D., Walworth, Wis., . . .	Hah. Med. Coll., Chicago, Ill., 1875.
MERRICK, MYRA K., M.D., Cleveland, Ohio, . . .	Central Med. Coll., Rochester, N. Y , 1852.
MASS, OSCAR B., M.D., Cleveland, Ohio, ...	Hom. Hosp. Coll., Cleveland, Ohio, 1870.
NICHOLS, CHARLES L., M.D., Worcester, Mass., . .	Harvard Med. School, Mass., 1875.
ORDWAY, LEONARD S., M.D., Hot Springs, Ark., .	N. Y. Hom. Med. Coll., N. Y., 1864.
PITCAIRN, HUGH, M.D., Altoona, Pa., ...	Hah. Med. Coll., Phila., Pa., 1880.
PORTER, PHIL, M.D., Detroit, Mich., ...	Long Island Coll. Hosp., N. Y., 1872.
POULSON, HARALDT L., M.D., Council Bluffs, Ia., .	Hom. Med. Coll. of Missouri, 1878.
ROCHE, EDWARD P., M.D., Bath, Me., ...	Med. Dep. Bowdoin Coll., Me., 1863.
RUSHMORE, EDWARD, M.D., Plainfield, N. J., . .	Jefferson Med. Coll., Phila., Pa., 1872.
RUSSEQUE, H. E., M.D., S. Framingham, Mass., . .	Boston Univ. School of Med., Mass., 1878.
SMITH, EDWIN, M.D., Aurora, Ind., ...	Pulte Med. Coll., Cincinnati, Ohio, 1873.
STORKE, EUGENE F., M.D., Milwaukee, Wis., . .	Hah. Med. Coll., Chicago, Ill., 1874.
STRONG, THOMAS M., M.D., Allegheny City, Pa., .	N. Y. Hom. Med. Coll., N. Y., 1871.
SWAIN, MARY L., M.D., Minneapolis, Minn., . .	Boston Univ. School of Med., Mass., 1877.
SWIFT, EVERETT M., M.D., New York City, . . .	N. Y. Hom. Med. Coll., N. Y., 1879.
TAYLOR, HENRY W., M.D., Crawfordsville, Ind., .	Eclectic Med. Inst., Cincinnati, O., 1872.
WALKER, GEORGE S., M.D., St. Louis, Mo., . . .	Jefferson Med. College, Phila., Pa., 1852.
WILLIAMS, DAVID R., M.D., Woodhull, Wis., . .	Western Hom. Coll., Cleveland, O., 1863.

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TREASURER'S REPORT.

E. M. KELLOGG, TREASURER, IN ACCOUNT WITH THE AMERICAN INSTITUTE OF HOMŒOPATHY, FOR THE YEAR ENDING JUNE 14TH, 1880.

DR.		CR.	
To balance on hand, June, 1879,	$895 15	1879.	
" collections up to June, 1880,	2769 00	July 25. By bill of Jackson Bros., Printing,	$39 25
	$3664 15	July 25. " Secretary for mailing vol. of 1878,	66 00
		Aug. 2. " Sherman & Co., Printing,	45 00
		Aug 13. " C. R. Morgan, Stenographer,	284 85
		1880.	
		Jan. 1. " W. J. Morgan & Co., Lithographers,	97 00
		Jan. 24. " Sherman & Co., Printing (miscellaneous),	60 50
		Jan. 24. " " " " for World's Convention,	112 75
		Feb. 4. " New Cash Book,	1 75
		May 13. " Packing and assorting vols.,	7 00
		June 11. " Secretary for Postage, Printing, etc.,	125 72
		June 12. " Treasurer " " " "	132 65
		Mch 26. " Contribution to World's Convention Fund, returned to Dr. Beckwith,	108 00
		June 11. " bill of Bureau of Organization, etc.,	33 39
		June 15. " Balance on hand,	2550 29
			$3664 15

AUDITORS' REPORT.

Accounts and vouchers examined and found correct.

D. H. BECKWITH,
I. T. TALBOT,
HENRY M. SMITH,
Auditing Committee.

MILWAUKEE, June 15th, 1880.

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TREASURER'S REPORT.

Report of E. M. Kellogg, Treasurer, upon the "World's Convention Fund," 1876.

Receipts.

From States:	
New York,	$915 00
Pennsylvania,	318 50
Massachusetts,	229 50
New Jersey,	184 00
Rhode Island,	105 00
Illinois,	86 00
Connecticut,	50 00
Indiana,	44 00
Wisconsin,	44 00
Maine,	43 00
Vermont,	32 00
Missouri,	28 00
Minnesota,	25 00
Tennessee,	16 00
Maryland,	10 00
District of Columbia,	8 00
*Ohio,	7 00
Louisiana,	4 50
Georgia,	4 00
California,	2 50
Total from State Contributions,	$2156 00
" " sale of vol.,	268 61
	$2424 61
To which add the assessment of $2.50 paid by 698 members,	1745 00
Total receipts,	$4169 61

Disbursements.

1876.	For Registration of Members and other expenses of the session in Philadelphia,	$46 51
1876.	For Translating, Editing, Printing, Electrotyping, etc., by order of Carroll Dunham, President,	1284 38
1879. Jan. 6.	For Printing, Stereotyping, etc., under order of Secretary McClatchey,	1000 00
1880. June 12.	For balance paid printer,	112 75
	Total Disbursements,	$2443 64
	Excess of Receipts over Disbursements,	1725 97
		$4169 61

The excess of Disbursements over Contributions and sale of vols. is $19 03

AUDITORS' REPORT.

Accounts and vouchers examined and found correct.

D. H. Beckwith,
I. T. Talbot,
Henry M. Smith,
Auditing Committee.

* At request of Dr. D. H. Beckwith, of Ohio, the sum of $108, of which $38 were contributions and $70 for vols. of 1876, was refunded on March 26th, 1880.

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IN MEMORIAM.

By Henry D. Paine, M.D., New York.

FRANKLIN BIGELOW, M.D., SYRACUSE, NEW YORK.

Dr. Bigelow was born July 13th, 1827, at Batavia, New York, but his father, Captain Joab Bigelow, is still living; removing to Michigan while Franklin was still young, the most part of his early life was spent in that State. Having but few opportunities for obtaining the kind of education which he desired, as soon as he attained his majority he returned East, with a view of prosecuting a more liberal and extended course of study than was attainable in the small town in which he lived. He had a strong proclivity for the profession of medicine, and directed all his efforts to prepare himself for that vocation. He passed some years in the improvement of his general scientific knowledge, and entered upon the special study of medicine under the direction successively of Dr. L. B. Wells, then of Pompey, and the late Dr. L. Clary, of Syracuse.

He graduated from the Homœopathic Medical College of Philadelphia in 1853, practiced for some time in Syracuse, in conjunction with his former preceptor, Dr. Clary, and then removed to Toledo, Ohio, soon after which he married, in 1856, Cornelia Williams, of Syracuse. He remained in Toledo about twelve years, enjoying gratifying success as a practitioner, but for the latter portion by degrees losing in health and strength, till finally he was driven from the field by the necessity of seeking a change of scene and climate. He returned to Syracuse, and still later went abroad with the same object in view. While in Germany his health was so far improved that he was able to avail himself of the famous clinical instruction to be had in the University and hospitals of Vienna.

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After his return, with partially restored health, he resumed his practice, but was frequently obliged to diminish his exertions and sometimes to suspend them, and in fact he continued more or less an invalid during the rest of his life. He died suddenly March 12th, 1879, in New York, whither he had gone for medical advice two or three weeks before. His age was 52 years. He was elected a member of the Institute in 1854, and was a member also of the New York State Homœopathic Medical Society, and was highly esteemed as a physician, greatly beloved as a man, a citizen, and a friend.

FREDERICK HOUSTON BRADNER, M.D., OF MIDDLETOWN, NEW YORK.

Dr. Bradner, whose death at the early age of 31 years is here recorded, was, of course, one of the later recruits to the ranks of the profession and of the Institute, having received his degree from the New York Homœopathic Medical College in 1873, and elected a member of this body in 1874. But though so young in the profession, he gave much promise of usefulness and success in his vocation. He was already engaged in a lucrative practice, and at the time of his death was President of the local Board of Health. The following resolutions were passed by the Orange County (New York) Homœopathic Medical Society at a special meeting convened on the occasion of his decease:

Resolved, That in the death of Dr. Frederick H. Bradner we recognize the chastening hand of Him who hath set a bound and limit to every life, and who in His infinite wisdom doeth all things well. We bow, therefore, in reverent submission to this mysterious decree, knowing that from the source of affliction comes also the balm of consolation.

Resolved, That we cherish in pleasant memory the virtues of our deceased brother, and seek by earnest emulation of those virtues to perpetuate the name and continue the influence of our departed friend.

ABRAHAM C. BURKE, M.D., OF BROOKLYN, NEW YORK.

Dr. Burke was one of the corps of "Seniors" of the Institute, having joined the society in 1848. He died April 15th of

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the present year aged 62. His father was a prosperous and upright merchant in Albany, New York, where this son was born.

He was prepared for college under the guidance of the once famous linguist and teacher, Dr. Bullions, at the Albany Academy. His intention was to become a clergyman, and he entered the Junior Class of Union College with that end fully in view. He graduated at twenty, and was Valedictorian of his class.

His health having become somewhat impaired, and his voice much affected, he reluctantly abandoned his design of entering the clerical profession, and turned his attention to medicine, but did not at once prosecute its study systematically, until, after a few years of travel and general reading, his health became measurably restored. Meantime his family had removed to Rochester, and he there entered the office of Dr. Ellwood as a pupil. He graduated as Doctor of Medicine from the Albany Medical College in 1845. He practiced for a short time in Rochester, but soon removed to Brooklyn. While attending the Eastern Dispensary, New York, he became interested in some cases that, after fruitless treatment according to the old way, were cured by homœopathic means. He pursued his examination of the new system with much diligence, and in a couple of years was strong enough in the faith of its superiority to avow his conversion. He established himself in South Brooklyn, then a sparsely settled district, where, in course of time, he gathered around him a large and appreciative body of friends and patients. A good physician, kind and generous to the poor, courteous and affable in manners, his departure has been the occasion of much grief in the great community which has grown up in that part of the city where he dwelt. It was not only in the medical profession that he acquired an enviable position, but he was zealous in many other good works. As a deacon of the Baptist society, of which he was one of the founders, for many years a faithful teacher of a Bible class, and a promoter of various charitable and religious objects, he will be long held in honor and reverence. His health was never very secure, but by a carefully regulated life and avoidance of all excesses he was able to pursue his professional and charitable labors with fewer interruptions than are usual to members of our arduous vocation. His funeral was at-

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tended by a large concourse of sorrowing friends, and his death was commemorated by numerous pastoral and editorial comments of a most favorable character. He married, in 1852, Miss Donner, a sister of the Hon. I. S. T. Stranahan, of Brooklyn, and had two children, a son and a daughter. The latter died many years ago. The widow and son survive.

LAFAYETTE BUSHNELL, M.D., OF NEW YORK.

Dr. Bushnell was born near Winchester, Va., October 12th, 1824, and died in New York city July 9th, 1879. He belonged to a family quite distinguished for the number of its members who have become clergymen, lawyers, and physicians.

He was educated with a view to the Presbyterian ministry, and, in fact, graduated from the Union Theological Seminary in New York in 1858; but doubts on some theological tenets made him hesitate to take any service in that capacity. He devoted his time to teaching and the study of languages, belles-lettres, and medicine. In 1868 he essayed again to take duty as a clergyman, and, after taking a course of instruction in Meadville Seminary, graduated there, and presently took charge of a Congregational Church in Charleston, South Carolina; but ill health compelled him to come North after a brief experience, and, finding that the condition of his lungs would disqualify him for preaching, he again turned his attention to medicine. This study he pursued with devotion, and, in due course, though late in life, was admitted to its honors. While he had strength for its duties he faithfully performed them, and was never weary of his self-imposed labor. His service was often unrequited, his mild and charitable disposition rendering him, too frequently, indifferent to the question of compensation. He was an indefatigable and universal student, and possessed a retentive memory. His knowledge on most scientific subjects was extensive, and his affability and command of language rendered his conversation most agreeable and instructive. His constitution, however, was hardly equal to the demands upon it, and he gradually fell into an illness, by which he was for a long time quite disqualified for any professional labor, and which, rather unexpectedly, terminated fatally in July last, in the 56th year of his age.

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He became a member of the Institute in 1870, and always took a great interest in its proceedings and in the improvement of medical science, although, owing to his indifferent health, he was seldom able to attend the meetings.

J. M. CADMUS, M.D., OF WAVERLY, NEW YORK.

Dr. Cadmus was born in Lodi, New York, July 3d, 1834, and died of apoplexy at Waverly, May 10th, 1879, in the 45th year of his age, and in the midst of his useful life. He received a good academic education and commenced the study of medicine under the direction of Dr. H. S. Benedict, of Havana, New York, and at the Western Homœopathic College, at Cleveland, Ohio. At this juncture he felt himself called upon to join the patriotic armies for the preservation of the Union. He at once engaged in raising a company for the 161st Regiment New York Volunteers, with which he served as Lieutenant and Captain for more than three years, and till honorably discharged in 1865. He participated in several engagements, especially at Port Hudson, Sabine Cross Roads, siege of Mobile, and Spanish Fort; and was twice seriously wounded, from the effects of which he never fully recovered. His bravery in action attracted the notice of his commanders and brought him offers of promotion, which he declined, preferring to remain with his comrades, who were warmly attached to him.

After his discharge from the army he resumed his studies, and graduated at Cleveland Homœopathic College in the spring of 1866.

After receiving his degree he commenced practice as a partner of his former preceptor, Dr. Benedict, who had, meanwhile, removed to Corning, Steuben County, New York. Subsequently he removed to Hammondsport, in the same county, and still later to Waverly, Tioga County. In each of these fields he was successful in gaining the confidence and support of a desirable clientage. In Waverly, where his last years were spent, he built up a large and remunerative practice. His death was sudden and unexpected, but his memory will long be held in honor by

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a grateful community. He was elected to this Institute in 1871, and was, besides, an active supporter and officer of several State and local societies, and an occasional contributor to the journals of our school. He married, in 1863, Miss H. A. Tompkins, of Sonora, New York, who, with her two children, are still living in Waverly.

WARREN FREEMAN, M.D., OF NEW YORK.

Dr. Freeman was born in Salem, Washington County, New York, May 23d, 1815. He received a good education in the usual high school branches. His father having died while this son was still young, he was early thrown mainly on his own endeavors. He had, however, a natural love of learning, and especially a strong predilection for medical science, and determined to make that the special object of his study. When 21 years old he was induced to go to the South with the expectation of making that section his permanent residence. He began the study of medicine about that time, but circumstances prevented the fulfilment of his plan for a number of years. It was not till 1850 that he began his collegiate course at the Homœopathic College in Philadelphia, and in 1854 obtained his doctorate.

He then removed to New York city, where he formed a partnership with the late Dr. Mairs, which lasted for many years. He died April 5th, 1880, aged 65 years. Few men of the same talents and professional ability have passed through life with less observation than Dr. Freeman. Although one of the most judicious and successful practitioners he was averse to any display, and rather sought to pursue the even tenor of his way, quietly but faithfully performing the duty of the day without seeking or desiring notoriety. Such, indeed, is the life of many a noble and accomplished physician, whose history presents but few incidents of interest to the public, but whose record lives in the memory of the services they have unostentatiously performed and the benefits they have, as it were, by stealth conferred. Now that he is gone, and men recall his worth, they wonder that he was not more distinguished and honored in his life.

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MICHAEL FRIESE, M.D., OF HARRISBURG, PA.

Dr. Friese was a native of Cumberland County, Pa. He was born near Carlisle, February 7th, 1832. For some years after the completion of his classical education he occupied himself in teaching. Dr. Lippe, now of Philadelphia, having observed qualities in the young man that he thought admirably fitted him for the vocation of a physician, was instrumental in directing his attention to that profession. His parents, being ardent adherents of homœopathy, were easily persuaded to favor that line of life, and afforded him every facility for acquiring a thorough medical education. After the usual course of reading, under the direction of Drs. I. K. Smith and J. Armstrong, he entered the Homœopathic Medical College at Philadelphia in 1856, from which institution he graduated with honor in 1860. He practiced for some time in Carlisle, but afterwards removed to Mechanicsburg, in the same county. His advent to that town was the signal that aroused the most determined opposition from the opponents of homœopathy, and tested severely the courage, patience, and self-control of the adventurous intruder. He was assailed with all the agencies which prejudice, jealousy, or malice could employ, and the system which he represented was abused and condemned without stint. By a steady adherence to his principles and a firm but conciliatory deportment he overcame the opposition, in a large degree, and secured the respect and confidence of a large body of patrons and friends. Afterwards, about 1866, he removed to Harrisburg, where he continued to follow his calling with eminent success until his death, which occurred February 4th, 1880. He joined the Institute in 1866, and was a member of the Pennsylvania State Homœopathic Society.

WILLIAM SCHEAFF HELMUTH, A.M., M.D., OF PHILADELPHIA.

Dr. William S. Helmuth was born in Philadelphia in the year 1801. His mother was Catharine Scheaff, who was sister to Mrs. Muhlenburg, mother of the Rev. Dr. Muhlenburg, of New York city. Dr. Helmuth entered the University of Penn-

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sylvania in 1815 (in which his grandfather, the Rev. Dr. Helmuth, was Professor of the German Language and Literature), and in 1819 received his degree of Bachelor of Arts. In due course the title of A.M. was conferred upon him. During his university course he evinced a strong partiality for scientific subjects, and immediately after the reception of his diploma turned his attention to medical subjects, and placed himself under the preceptorship of Dr. T. T. Hewson, then a distinguished surgeon of Philadelphia, and the contemporary of Physick, Wistar, Dewees, and those illustrious men who made, in those early days, the reputation of the university. Dr. Helmuth received his degree of *Doctor Medicinæ* in 1823.

It was during the days of his student life that a friendship arose between himself and Dr. James Kitchen, also a student of Dr. Hewson's, which continued unbroken until the death of him whose short obituary is now being written. At the funeral ceremonies it was touching in the extreme to witness the surviving friend standing bareheaded beside the grave of one he had known through youth, manhood, and old age, had faithfully attended through a long and distressing illness, and now paid the last tribute of respect to him whom he had loved during a long and eventful life.

Immediately after his graduation Dr. Helmuth entered actively upon the practice of his profession, and was soon after appointed one of the physicians to the Moyamensing Almshouse, which post he creditably filled for a number of years. His practice steadily increased, and his friends became more numerous, until the duties of his calling were almost too great a burden for his health. It was about this period that he became subject to a most severe and frequently recurring neuralgic affection of the heart, which often prevented his attention to business, and confined him to the house for days together. The symptoms of the affection were great anxiety, severe pain, with palpitation and faintness. The most distinguished of his *confrères* were unable to relieve his distress, though the usual expedients of the day were thoroughly tried—bleeding, leeching, cupping, and blistering were often, though ineffectually, resorted to. The writer of this notice has frequently been told that Dr. Helmuth often

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visited his patients with his chest raw from the blisters that had been applied to relieve him. It was about this time (1839) that Dr. Kitchen, who had been perfecting his medical studies abroad, and who had returned a homœopathist, was consulted, and Bryonia 3d was prescribed with almost instantaneous relief; and throughout the remainder of his life, when threatened with such attacks, this medicine would always relieve him.

Dr. Helmuth was too honest in his convictions, and too sincere a searcher after truth, not to openly acknowledge the wonderful action of this medicine, and began immediately to make further investigations into homœopathy. This he did with great system and carefulness for several years, necessarily struggling with the opinions of the school in which he was born and reared, with the principles of which he was thoroughly imbued. The result was an open avowal of homœopathy, and the ostracism of his former professional associates. To the day of his death, however, he never swerved from his strict adherence to the principles of Hahnemann, and a more careful physician or conscientious prescriber never lived.

In 1846 Dr. Helmuth was elected Professor of the Theory and Practice of Homœopathy in the Homœopathic Medical College of Pennsylvania, of which institution he was also a trustee. This position he occupied for several years, but his great modesty, which amounted in many instances to diffidence, made lecturing a distasteful labor, and after a few years he resigned his chair and devoted the rest of his life to general practice. His knowledge of disease was extensive, his reading most exhaustive, his powers of observation keen, and his knowledge of the Materia Medica thorough. He individualized and studied every case of importance which was intrusted to his care, and the patient investigation which he bestowed upon chronic cases could scarcely be equalled. His patients loved him because he was a true man.

About three years before his death, which took place on April 9th, 1880, he was struck with paralysis, which terminated his life after a long and distressing illness, which he bore with Christian fortitude and resignation. To his immediate family his loss seems irreparable, and this society cannot but join with

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his nearer friends in sorrowing over the grave of one of its most worthy and venerated founders.

Dr. Helmuth joined the Institute immediately after its organization, and always took a deep interest in its work and prosperity.

CHARLES JULIUS HEMPEL, M.D., OF GRAND RAPIDS.

The name of Hempel has been so long familiar to the readers of homœopathic literature that it has almost come to be considered as an integral part of the school itself. As an author, translator, compiler, and critic, Dr. Hempel exercised for years a wide and powerful influence among homœopathists, not only in America, the country of his adoption, but wherever the doctrines of Hahnemann have attracted any favorable attention. It cannot but be a cause of supreme regret that his name has now to be inscribed upon the tablet of departed worthies.

Charles Julius Hempel was a native of Prussia, born in Solingen, September 5th, 1811, and received a university education, not only in Germany, but in France, whither he repaired after passing his examination at home. In Paris he had the distinguished honor of forming the acquaintance of Michelet, the Professor of History and author of the *History of France.* While residing in Paris he became acquainted with a number of Americans, through whose persuasion he was induced to visit the shores of the New World. He arrived in New York, September 5th, 1835, his twenty-fourth birthday, and at once devoted himself to the task of acquiring a critical knowledge of the English language and literature.

It so happened that among his literary and scientific associates—and they were some of the most distinguished members of society—there were several who had become ardent disciples of the homœopathic system. Having decided upon medicine as his future profession, he pursued its study with the enthusiasm and diligent application characteristic of his nature. He became a member of the then newly created University Medical College, and was one of its earliest graduates. Having secured the honors to which his scholarship entitled him, he at once undertook to extend his own knowledge of homœopathy, for which he had

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already acquired a great admiration, and at the same time to facilitate its wider dissemination, by translating into English some of the most important foreign works upon the subject. This labor of love was duly appreciated by the rising school of homœopathists, and the favor with which his publications were received encouraged a continuance of similar contributions. During many years the emanations from his ever-active pen were frequent and often voluminous. It would require too much space to enumerate a catalogue of the works which were ushered into light by means of his diligent efforts.

They embrace many volumes of highest practical value to the practitioner and student—works of daily reference and permanent value, *e. g.*, Hahnemann's *Materia Medica Pura*, in four volumes; *Chronic Diseases*, five volumes; Jahr's *Symptomen Codex and Repertory*, in three large volumes; Raue's *Organon of Homœopathy;* Teste's *Materia Medica;* Hempel's *System of Materia Medica and Therapeutics;* and many others.

For three years he occupied the important chair of Materia Medica and Therapeutics in the Homœopathic Medical College of Philadelphia. The death of his father-in-law required him to remove to Grand Rapids, Michigan, to take charge of the family estate. There, however, he continued his usual active literary and professional labors, and soon became engaged in an extensive practice, which he continued until the unfortunate failure of his health obliged him reluctantly and gradually to yield to the inevitable necessity, and finally, from complete blindness and other disabilities, to cease entirely from all labor. He had been long an invalid, tenderly and faithfully watched and cared for by his loving family, and, for himself, patiently and confidently waiting for his departure. He died September 24th, 1879, at Grand Rapids, Michigan, aged 68 years.

Not long before his removal to Philadelphia, he married the daughter of George Coggeshall, Esq., one of the founders of the beautiful city in which the latter years of his life were passed. Wherever he lived, his gentle manners and genial disposition, his large acquirements and ready discourse, attracted the association of the wise and the admiration of all.

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Dr. Hempel was one of the veteran founders of the Institute, and was formerly a regular attendant at its sessions.

HARRISON V. MILLER, M.D., OF SYRACUSE, N. Y.

The subject of this brief notice was one of the most active and useful members of our school in Central New York. He died November 26th, 1879, aged 51 years. Several years before his death he suffered an attack of paralysis, which left him more or less an invalid the rest of his life, and a second attack which was the immediate cause of his death. But though partially disabled from the fulfilment of all the work for which his mind and education well fitted him, he never lost his interest in science generally, or in medicine.

Dr. Miller was born in the town of Apalia, Onondaga County, New York, September 17th, 1828, and passed all his professional life in the same county. After graduating from Hamilton College in 1851 he taught school in Mississippi, Ohio, and California for several years. Having then decided upon medicine as his permanent profession, he returned to his native State and entered upon his preparation. Soon after he suffered from an obstinate ophthalmia, which would have greatly delayed his progress but for the assistance of his wife, who read the different textbooks aloud to him, and afterwards examined him upon the subject treated of. During the first year she was his only preceptor. He graduated at the New York Homœopathic Medical College in 1862, and practiced in Pompey Hill and Jordan, New York, and finally in Syracuse till his death. In all the relations of life, as a physician, a scholar, a citizen, he was sincere, earnest, progressive. He deservedly won the esteem and respect even of his opponents by the gentleness of his manners and his superior attainments. He became a member of the Institute in 1871, and was connected with a number of other medical and scientific societies.

ERASTUS A. MUNGER, M.D., OF WATERVILLE, N. Y.

Few members of our school in Central New York have been so highly esteemed, or more widely known, than the subject of

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this notice. He was the pioneer of homœopathy in Oneida County, New York, and for years was the object of much contumely and ridicule by his former professional friends.

Dr. Munger was a native of Lewis County, New York, and enjoyed the advantages of the best medical educational opportunities then available in the State. He had for preceptors at different times, Drs. Haven, of Waterville; Welcome Clark, of Whitesboro'; and Frank H. Hamilton, now of New York city. His collegiate instruction was obtained partly at Fairfield, New York, and partly at Jefferson Medical College in Philadelphia, where he graduated in 1835, being then 22 years old.

He practiced medicine in Waterville, where for a young man he met with reasonable success. At that time homœopathy had scarcely been heard of in that part of the State. But in a few years his active and inquiring mind was aroused by the reports of the progress which the new method was making in other directions, until he became inspired with a desire to examine into its pretensions, and finally a determination to study it where he could have the best opportunity to observe its practical workings. In 1843 he went to New York for this purpose, and put himself in communication with a number of the most prominent practitioners of the new system, under whose direction he, for several months, gave himself up to this investigation. Drs. Gray, Freeman, Bayard, and others with whom he conferred, afforded him all the necessary facilities for his purpose.

With such a disposition, and enjoying such opportunities, the result could not but be to satisfy him of the advantages of the homœopathic method, and of his duty to qualify himself to practice according to its principles. He lost no time in setting about this work, which he pursued with the earnestness and thoroughness which were a part of his nature. On his return to his field of labor, the open avowal of his change of opinion drew down upon him the ridicule of his colleagues and produced no little excitement in the community generally. Not daunted, however, by the doubts and apprehensions of his friends, nor the opposition and derision of the doctors, he maintained his course without misgiving. Adherents and patients were not long in gathering to his support, and his success and popularity soon demon-

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strated the soundness of his judgment and the courage of his position. The opposition he experienced, however, had the effect of awakening the attention of some of his younger brethren in the profession to the cause of the persecution, and inducing them to rally in defence of the right of freedom of medical opinion. Of these several afterwards became converts and still live to testify to the persuasive influence of Dr. Munger. He lived to see the system of which he was the solitary pioneer, adopted and practiced by large numbers of the profession in Central New York, and accepted and supported by the most intelligent and influential of the community.

He joined the Institute in 1848, and has been upon the list of *Seniors* since 1873. He was a leading spirit in the different State and local organizations for the defence and propagation of homœopathy, and has been recognized for many years as a representative and able champion of the system. His death, which occurred November 4th, 1879, was preceded by a long and gradual failure of health, with little evidence of disease, and he quietly passed away without pain or suffering, leaving an honorable record, not only as a capable and humane physician, but as a man and citizen of irreproachable character.

MARQUIS DE NUÑEZ, OF MADRID, SPAIN.

As well on account of his profound learning and his long services in behalf of homœopathy, as because he was an honorary member of this body, is this distinguished physician entitled to a special commemoration in the record of the honored dead of this Institute. His death at Madrid, November 10th, 1879, produced a profound sensation, not only among his particular followers, but throughout the community of which he was a prominent and venerated member, and was followed by the most expressive demonstrations of the love and respect widely entertained for him.

He was of a noble and distinguished family, and was born at Benaventi, in Zamora, April 27th, 1805. His education was, according to his rank, of the most liberal kind. At 20 he commenced the study of the law; but, after making considerable progress in that direction, he was persuaded by friends to change

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his plans, with a view of entering the priesthood. Upon the outbreak of the war for the Spanish succession he joined the party of the Pretender, but, being displeased with the conduct of the business, he abandoned Don Carlos, renounced politics, and removed to France.

He now found he had a predisposition to the study of medicine; he resolved to qualify himself for its duties. He entered upon the study with his usual zeal and impetuosity. Fortunately, his attention was arrested in the early period of his studentship by the new medical philosophy propounded by Hahnemann, which by that time had made some headway in France. He read all the works then to be had, both upon the theory and the practical application of the doctrines. The Materia Medica was the special object of his desire for knowledge. Having the advantage of an extraordinarily retentive memory, he was able to conquer the details of that difficult branch to a remarkable extent.

In applying his knowledge to the treatment of such cases as applied to him, which he did without remuneration, he aroused a powerful spirit of antagonism on the part of the "regulars" of the profession. The accusation upon which it was resolved to arrest him was that he practiced without a license. He was found guilty of the charge and fined *one franc*. But the success that followed his treatment in a number of important cases induced a number of influential Spaniards to prevail upon the Spanish government to allow him to return, take his degree, and practice homœopathy. These efforts were at length successful, and, in 1844, Nuñez returned from his exile to Spain, passed the necessary examination, and received his doctorate from the University of Barcelona.

From that time he resided in Madrid, and spent his whole life and means in the cause of homœopathy. He was not by any means the first to practice that system in Spain, but his extraordinary zeal and powerful influence did more than all others to establish and extend it, not only in Madrid but throughout Spain. By his efforts the Hahnemannian Society of Madrid was organized, of which for many years he was the President. The organ of this society, *El Criterio Medico*, still published, is filled with his numerous contributions on medical subjects, many of

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them of great practical value. His great effort was for the establishment of a hospital in Madrid, and to that object he devoted not only his personal labor but munificently of his fortune. When it was at last erected he took up his residence therein for the rest of his life, and at his death endowed it with the sum of $375,000 in addition to his previous contributions. He was honored abroad as well as at home, and received from several courts particular marks of distinction.

JOHN AUGUSTINE WARD, M.D., OF NEW YORK.

Dr. Ward—a younger brother of our veteran "Senior," Dr. Isaac M. Ward—was born October, 1826, in Bloomfield, New Jersey. He received a liberal education, the collegiate part of which he obtained at Oberlin, Ohio. He pursued his medical studies under the direction of his brother, then practicing in Albany, New York, and graduated from the medical college in that city at the age of 21. Soon after he removed to Reading, Pa., where his only sister, the wife of an eminent clergyman, then resided. Here he commenced, under favorable auspices, the practice of his profession, in which he attained good success. After about four years he removed to Burlington, Vermont. While residing there he spent a year in New York city, perfecting himself in a review of his medical studies, and attending a course of lectures and clinics at the University of that city, and receiving its diploma in the spring of 1854. The following year he went to Philadelphia, and was associated in practice with the late Professor William A. Gardiner. He had already received the honorary degree of M.D. from the homœopathic college there. He subsequently removed to the city of New York, where he remained until his death, which occurred March 5th, 1880. He was elected a member of the Institute in 1856, and was also a member of several other societies for the promotion of medical and other scientific objects. He was an able practitioner, and had the confidence of an intelligent body of patrons, and by his genial and pleasant manners made numerous friends, particularly in literary and artistic circles. He had for some months complained of shortness of breath and imperfect digestion, but

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his death was unexpected, and was afterwards found to have been the result of extensive degeneration of the liver.

W. H. WOODYATT, M.D., OF CHICAGO, ILL.

Not many members of our profession have died at thirty-four with a reputation, for skill attained and success achieved, higher than that which belonged to the lamented subject of this short memorial. This is the more noteworthy on account of the difficulties he had to contend against in treading the road to knowledge. He was born in the province of Ontario, September 12th, 1846. Such education as he received was at the common schools of his neighborhood, and before he was sixteen. At that age he entered the office of the Montreal Telegraph Company, and soon acquired such expertness as an operator and such knowledge of the business that at nineteen he was put in charge of the important office of the company at Kingston. Here his time was less constantly engaged, and he began to fill up his leisure moments in reading medical works. His partiality for medicine as a profession was thus fostered, and finally became so strong that he entered upon a regular system of study in the office of Dr. H. C. Allen, of his native town. Subsequently he completed the required course of collegiate instruction in the Cleveland Hospital College, and under the special tuition of Professor Biggar. Having graduated with high credit at this institution he resolved to qualify himself as an ophthalmic surgeon, and to devote his professional efforts entirely to that department. With this end in view he decided to go to New York, where he spent two years in attendance on the lectures and clinics of Dr. Knapp, at the New York Ophthalmic and Manhattan Hospitals. Being still without other resources than of his own personal labor, he sustained himself by working as telegraph operator in the office of the Associated Press. His character as an expert in telegraphy secured him ready employment in the intervals of his study.

After this thorough preparation, Dr. Woodyatt established himself in Chicago. His ability as an oculist and aurist was soon apparent, and he was presently appointed as lecturer on his special subjects during the spring course of the Hahnemann

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Medical College. As a teacher he acquitted himself so satisfactorily that his appointment as professor followed, and he delivered a full course of instruction in his department in the next regular winter term. As a lecturer his style is said to have been marked by great clearness, method, and accuracy. His own earnestness was a constant stimulus to the students. When the Chicago Homœopathic College was organized he accepted the same position in that institution, and was an influential worker in its management. Thus his early death was a great loss, not only to his large and increasing body of patients, but to the cause of education and progress. His brief but fatal sickness was malignant diphtheria. He died January 31st, 1880, after a week of much suffering, with the full consciousness of the approaching result. He was taken down while in the fulness of his strength, and taken away in the early stages of a career of usefulness and fame. He was elected a member of the Institute in 1873.

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ADDENDA

TO THE PROCEEDINGS OF THE THIRTY-THIRD SESSION.

RECEPTION OF PROFESSOR DANFORTH.

AFTER the adjournment of the evening session of June 16th, the members of the Institute and the ladies in attendance, repaired to the elegant residence of Professor Danforth (eligibly located on Jefferson Street, Milwaukee), to attend the reception tendered to them by the Professor during the morning session.

On their arrival they found the mansion brilliantly illuminated, and a band of music playing a march of welcome. On entering the hall they were politely ushered into the spacious drawing-room, tastily decorated with flowers, paintings, statuary, etc., where they were most cordially received and heartily welcomed by the professor and his accomplished wife. After a brief period of introductions, handshaking, and social "chit-chat,' interspersed with appropriate music by the band, all seemed to feel at home. None, however, anticipated the surprise that awaited them until entering the dining-room, where refreshments were served in profusion in Mr. Conroy's best style, and under his personal supervision, and of which the guests partook with the relish of epicures. The company dispersed at a late hour, delighted with the evening's entertainment, wishing their host and hostess a long life of unalloyed pleasure.

RECREATIONS.

The Local Committee of Arrangements, through its most efficient and indefatigable chairman, Dr. C. C. Olmsted, made ample provision for the enjoyment of the ladies during the hours the Institute was in session, by carriage drives, pleasure excursions, etc.

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The Soldiers' Home, a few miles drive from Milwaukee, the extensive conservatory of Mr. A. Mitchell, which adorns the grounds of his palatial suburban residence, and other places of interest were visited under the escort of the wives and daughters of the Milwaukee physicians. In brief, the fraternity and their wives and daughters were assiduous in their attentions from the arrival until the departure of their guests, causing the hours to "swiftly glide." Our visit to Milwaukee, like "a thing of beauty," will be to us "a joy forever."

COMPLIMENTARY BANQUET.

Thursday evening, June 19th, the members of the Institute, the ladies in attendance, and invited guests, including the mayor, representatives of the press, and the State Board of Health, assembled at 8 o'clock in the spacious *salon* of the Newhall House, to partake of the sumptuous repast provided for, and tendered to them by the proprietors, Messrs. J. F. Antisdel & Son. For an hour and a half a choice bill of fare was discussed by about two hundred and fifty guests. The brilliant company, the elegant toilets of the ladies, the display of fruits and flowers, the decorations of the dining-hall, and the glitter of table-ware, reflected by the brilliant electric light, formed a *tout ensemble* alike imposing and inspiring. About ten o'clock the cloth was removed and the assemblage called to order by the General Secretary, who requested Dr. R. Ludlam to act as toast master of the evening. Dr. Ludlam gracefully accepted the position in a few facetious remarks, when some eight or ten regular toasts were announced, and responded to by as many different persons. Between each toast Hutchin's Orchestra discoursed appropriate music in artistic style.

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REPORT

OF THE

BUREAU OF MATERIA MEDICA, PHARMACY, AND PROVINGS.

J. P. DAKE, M.D., CHAIRMAN,	Nashville, Tenn.
C. WESSELHŒFT, M.D.,	Boston, Mass.
W. L. BREYFOGLE, M.D.,	Louisville, Ky.
T. F. ALLEN, M.D.,	New York, N. Y.
J. F. COOPER, M.D.,	Allegheny, Pa.
LEWIS SHERMAN, M.D.,	Milwaukee, Wis.
C. H. LAWTON, M.D.,	Wilmington, Del.
H. M. PAYNE, M.D.,	Albany, N. Y.
J. EDWARDS SMITH, M.D.,	Cleveland, Ohio.
A. C. COWPERTHWAITE, M.D.,	Iowa City, Ia.

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INTRODUCTORY REPORTS.

By J. P. Dake, M.D., Chairman, Nashville, Tenn.

GENERAL INTRODUCTORY.

It is one of the duties of a chairman to present a *résumé* of the discoveries and improvements in the department of medicine committed to his bureau. My excuse for the omission of such service, on this occasion, is that, so little time is given for the presentation and discussion of the special subject selected, we cannot afford to introduce other topics, however interesting.

I must remark, however, in this connection, and for the benefit of my successors, that authors of books and pamphlets, relating to the interests committed to this bureau, and introducers of new articles of *materia medica*, or improved appliances in pharmacy, should send copies and specimens to the chairman, for his examination and notice. In no other way can he be expected to make mention of them properly in his annual report.

Only two books on materia medica, out of several, published during the last two years have been thus sent to me, namely, that of Dr. H. C. Jessen, on *Therapeutic Materia Medica*, and that of Dr. Carl Heinigke, translated into English by Dr. Tietze, on *Pathogenetic Outlines of Materia Medica*. These are important works, valuable alike to the student and the busy practitioner.

Before proceeding to the introduction of our special subject I must notice briefly a very important communication, addressed to this bureau by the American Ophthalmological and Otological Society, reading as follows:

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BUFFALO, N. Y., July, 1879.

To the Chairman of the Bureau of Materia Medica, Pharmacy, and Provings, in the American Institute of Homœopathy, JABEZ P. DAKE, M.D, Nashville, Tenn.

At the third annual session of the American Ophthalmological and Otological Society, held at Fort William Henry Hotel, Lake George, June 24th and 25th, 1879, the following motion prevailed:

That a committee of three be appointed by the President for the purpose of conferring with the chairman of the Bureau of Materia Medica, Pharmacy, and Provings, in the American Institute of Homœopathy, with the view of perfecting the ophthalmic and aural examinations, during the proving of remedies.

In fulfilling the spirit of this motion, the committee would suggest to the bureau the advisability, should it meet your approval, of having careful examinations of the eye and ear made by specialists, before, during, and after the action of the drug; the former, to determine the condition of the visual function of the fundus, of the accommodation, of the refraction, and of the extrinsic muscles; and the latter, to show the state of the external auditory canal and *membrana tympani*, with a careful record of the hearing power.

All of which is most respectfully submitted.

F. PARK LEWIS, M.D., Buffalo,
H. C. HOUGHTON, M.D., New York,
W. H. WOODYATT, M.D., Chicago.

This communication, coming into my hands after the adjournment of the Institute at Lake George, too late for submission to the bureau, I had it published in some of our journals, with comments, in order the sooner to draw the attention of the profession to its important hints.

The high standing of the society sending us this appeal, as well as the great importance of the object aimed at, calls for more than a passing notice. If practitioners, dealing with affections of the eye and ear, believe in the homœopathic principle, it is but right and necessary that they should seek to know exactly how the various articles of *materia medica* influence the conditions and functions of the human eye and ear. If they have found improved means of diagnosis in the study of diseases of those organs, it is but right and necessary that they should have such means applied in the diagnosis of corresponding drug affections.

If they require a *similimum* it is of prime importance that the *similimum* should be of the highest order, a well-ascertained fact and not a creation of fancy.

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What they ask for, and what is needed by every practitioner under the homœpathic law, is the removal of the work of drug proving from the field of the busy practitioner, from the hands of the untaught student and the enthusiastic layman, to the physiological laboratory, where trained provers, male and female, under the guidance and scrutiny of expert observers, may furnish a faithful reflection of drug influence in the human organism.

Hahnemann did what he could, with the means at his command, towards building up a genuine and sufficient drug pathogenesy; and we are happy, in this large assemblage of his disciples and in these triumphal days of homœopathy, to bear witness that, with all its imperfections, the *Materia Medica* of the master and of his followers is far ahead of anything bearing the name Materia Medica that the world has ever seen. So valuable has it been considered by those who write textbooks for the old school of medicine, it has been freely drawn upon by them; but, much to the shame of the borrowers, without acknowledging, in preface or by footnote, the source of the wealth obtained.

So increased has become the appetite of our traditional adversaries for pathogenetic knowledge, it becomes us to look well to our laurels, lest by the adoption of the more exact methods of the day, they may cause the glory of the *healthy vital test* to depart from us and to adorn the experimental laboratories of their seats of medical learning.

Let us heed the call of our brethren of the Ophthalmological and Otological Society, and inaugurate more thorough methods of drug experimentation.

SPECIAL INTRODUCTORY.

In the meeting of the Institute at Lake George, last year, owing to the great number of papers in the several bureaus seeking to be heard, it was not possible for this bureau to submit its full report.

Under the circumstances it was thought best to reserve the

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last two divisions of our subject for consideration during the year and presentation at this meeting. The divisions so deferred embraced the proofs of drug presence and efficacy in attenuations above the 6th decimal.

For convenience and the more efficient handling of our subject we made sections and assignments of our work as follows:

I. *The Proofs of Drug Presence and Power in Attenuations above the Sixth Decimal:*

1. As Furnished by the Tests of Chemistry: W. L. Breyfogle, M.D.

2. As Furnished by the Spectroscope and Microscope: C. Wesselhœft, M.D., J. Edwards Smith, M.D.

3. As Furnished by the Tests of Physiology: T. F. Allen, M.D., Lewis Sherman, M.D.

4. As Furnished by Analogy from the Field of Impalpable Morbific Agencies: J. P. Dake, M.D.

II. *The Proofs of Medicinal Presence and Efficacy in Attenuations above the Sixth Decimal:*

1. As Furnished by the Tests of Clinical Experience in the Use of Attenuations, Ranging from the Sixth to the Fifteenth Decimal: J. F. Cooper, M.D.

2. As Furnished by Clinical Experience in the Use of Attenuations, Ranging from the Fifteenth to the Thirtieth Decimal: A. C. Cowperthwaite, M.D.

3. As Furnished by Clinical Experience in the Use of Attenuations above the Thirtieth Decimal: C. H. Lawton, M.D., H. M. Paine, M.D.

This *schema* of our work we had printed months ago in circular form and sent to all of our journals, most of which gave it an insertion and favorable notice. In order to gather from the observations and experiences of the profession at large, and of the scientific world outside, such facts as might aid our inquiries, we had the following appeal added to our *schema* and sent out in all directions:

"The bureau will be pleased to receive items of information and experimental aid from members of the profession, and also from scientific persons outside who may be interested in any division of our subject."

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In regard to the constitution of the bureau itself and the subject selected for consideration I should say that, in but one instance, have we been called in question. Our motives have been somewhat impugned and our fairness questioned, with some detriment I fear to our endeavors to gather for this occasion all possible proofs of the power and efficacy of our drug attenuations.

In regard to the third section of our second division, embracing "Proofs Furnished by the Tests of Physiology," I should mention that we shall not be able to present all that we had hoped at the beginning of the year. It will be remembered that, at Lake George, Dr. T. F. Allen declared before the Institute, *that if six bottles of liquid, to all appearance exactly alike, one only being medicated, and that with the thirtieth centesimal dilution, were submitted to him, he would pick out the medicated bottle by the effects of its contents upon the human organism;* and, further, *that he believed he could thus pick out the thirtieth as often as the advocates of the low attenuations could the sixth under like circumstances.* Taking the doctor as in earnest I placed him upon the bureau, in order to have him apply the test proposed, in the development of proofs for this occasion, proofs so well guarded as to be above question.

I asked Dr. Allen and Dr. Sherman to take charge of all physiological experiments,—the former, of those pertaining to the 60th, and the latter, of those pertaining to the 6th decimal.

I requested Dr. Sherman to submit such safeguards for the preparation, marking, and care of the bottles to be furnished to Dr. Allen as would preclude all doubts as to the entire fairness of his test, and at the same time I requested Dr. Allen to do a similar work for the security of the experiments to be conducted by Dr. Sherman.

But, in place of going on with the work as laid out, Dr. Allen resorted to the President-elect of the Institute for a special commission to take charge of the preparations for his test, as though this bureau were incompetent or unwilling to deal officially and fairly with his undertaking.

Afterward, when brought to see his mistake, he declined the experiments entirely for the year, upon the ground of impaired health.

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I mention these facts simply to account for the absence of results earnestly looked for by the profession, in view of Dr. Allen's proposal at Lake George, and the subsequent announcements made by this bureau.

Dr. Sherman, under rigid safeguards, went forward with the 6th decimal, developing proofs which, I am sure, will be gratifying to all who have believed that there is medicinal power in attenuated drugs.

In advance of the papers now to be read I must beg the earnest attention of all present to each fact and argument submitted, so that no misapprehension may occur as to the purposes and spirit of this bureau relating to the questions before us.

Some of the discussions which followed the reading of the papers of this bureau, last year, exhibited a wonderful misapprehension as to the subjects brought forward and positions assumed in them. In place of showing any errors of statement, or weakness of logic on the part of the authors of the papers presented, and, so far from shedding any additional light upon the matters under consideration, an attempt was made to lecture members of the bureau upon their supposed heterodoxy and their recreancy to the teachings of Hahnemann.

On this occasion I beg those who discuss our papers to keep in mind the real questions presented, and not to run off wildly, under a sense of horror or fear, lest the great temple of homœopathy be overturned.

In matters of science there should be a calm listening and looking to statements made, with a freedom from prejudice and a disposition to accept the truth, however much it may contradict what we have previously cherished as true.

All appeals to passion or prejudice, all closing of doors to full and free investigation, and all shrinking and hiding from the light, are unbecoming the members of this learned body, the cause we would further, and the age in which we live.

Not a member of this bureau has desired to suppress facts or discolor the truth, however earnest in the advocacy of cherished views. Not one has had a wish to weaken the foundation or mar the superstructure of homœopathy while combating the views of others.

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We do not all agree—upon some points we differ widely—but I am persuaded we differ honestly, and with sentiments of personal respect for each other.

In closing my introductory to the reports now to be submitted, I beg leave to say that, as the senior member of this bureau, having served upon it almost constantly for a quarter of a century, and during these two years as its chairman, I must be allowed to retire from all official work in connection with it.

The duties of these two years have been performed by me with the determination of retirement and a purpose to have my last work well done.

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THE PROOFS OF DRUG PRESENCE AND POWER IN ATTENUATIONS ABOVE THE SIXTH DECIMAL, AS FURNISHED BY THE TESTS OF CHEMISTRY.

By William L. Breyfogle, M.D., Louisville, Ky.

As you are all aware, gentlemen, the *science of chemistry*, as applied to homœopathic dilutions, cannot be proof conclusive of the existence of medicinal power, but as it is to become an important part of the proceedings of this bureau, I have endeavored to give the subject a thorough test. For this purpose I obtained on the 29th day of last August, from a reliable homœopathic pharmacy, two ounces each of Arsenicum 3d, 6th, 12th, and 30th decimal dilutions; of Nux vomica 3d, 6th, 12th, and 30th, and of Sulphur 3d, 6th, 12th, and 30th. The seals were left untouched, but the labels were removed, and in their stead numbers were placed on each vial and a corresponding entry made in a private book.

The vials were then turned over to J. P. Barnum, M.D., analytical chemist, with the understanding that each should be separately examined, using new apparatus for each test, and under the direct supervision of Professor C. Leo Mees and myself. No mention was made of the contents, excepting that Nos. 5, 6, 7, and 8 contained vegetable, and the rest mineral substance.

Test No. 1.

No. 1 (representing Ars. 3^x dil.) was then acidulated and treated, according to the usual method for determining unknown mineral substances, with no result until saturated with sulphuretted hydrogen, when a yellow precipitate was thrown down. Redissolving and applying Reinsch's tests, the copper was coated

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with a metallic film, which on being sublimated, deposited on the glass tube distinct octohedral crystals of Arsenious acid, with crystals of Sulphur and some resinous matter, the latter from the alcohol, and the Sulphur arising from the decomposition of the Sulphuret of arsenic. On further examination the liquid was found to contain no other metallic substance.

Test No. 2.

No. 2 (representing the 6th dil. of Ars.) was then similarly treated. The metallic copper was slightly stained, and on being sublimated, Sulphur, resinous matter, and a few *indistinct* octohedral crystals were shown, not sufficient in number or distinct enough in form to determine their nature. Suspecting that they did not arise from the substance under examination, perfectly pure *distilled water* was similarly treated, and similar deposits of Sulphur and crystals occurred, showing that there had been a slight trace of Arsenic in the Muriatic acid used.

A solution containing $\frac{1}{50000}$th of a grain of Arsenic was then similarly treated, and the copper was covered with a distinct steel-colored tarnish, which, on sublimation, yielded distinct crystals.

A solution containing $\frac{1}{100000}$th of a grain of Arsenic was next treated. The copper was slightly tarnished and yielded minute but distinct octohedral crystals of Arsenious acid.

It was then concluded that No. 2 contained only alcohol and water.

Tests Nos. 3 *and* 4.

Nos. 3 and 4 (representing the 12th and 30th dil. of Ars.) were then each separately examined (using a fresh supply of acid, which showed absolutely no arsenical reaction) and no traces of anything but alcohol and water discovered.

The limit to which a chemist is willing to certify, as to the presence or absence of Arsenic, is from $\frac{1}{50000}$th to $\frac{1}{100000}$th part of a grain, yet a *crystal* measuring $\frac{1}{10000}$th of an inch, and weighing less than $\frac{1}{10000000000}$th of a grain, may be distinctly recognized.

No such crystals were found in the 6th, 12th, or 30th dilutions, the 3d dilution alone showing traces of Arsenic.

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As the substances contained in the series 5, 6, 7, and 8 were understood to be vegetable matter, they were carefully examined for the alkaloids.

Test No. 5.

No. 5 (representing Nux vom., 3d dil.) was evaporated slowly to dryness, dissolved in a small quantity of water, acidulated with acetic acid, and subjected to the color-test, and the absence of any known alkaloid determined.

The reaction of more than fifty of these substances are known, and solutions containing $\frac{1}{50000}$th of a grain of Strychnine gives perfectly distinct reaction, while the $\frac{1}{100000}$th part of a grain yields a fine display of colors.

Test No. 6.

No. 6 (representing the 6th dil.) was slowly evaporated to dryness, redissolved in a small quantity of slightly acidulated water, and injected into the circulation of a small frog, which was not in the least affected by it, while on the injection of the $\frac{1}{10000}$th of a grain of Strychnine the animal was thrown into convulsions within six minutes, and died immediately afterward.

Considering the relative weight of the frog and the human subject, the administration of $\frac{1}{10000}$th of a grain of Strychnine to a frog would be about equal to the administration of four grains to a human subject weighing one hundred and forty pounds; and the injection of the active principle in the contents of vial No. 6 equals the injection into the human system of the active principle contained in $43\frac{35}{56}$ gallons of water.

Tests Nos. 7 *and* 8.

Nos. 7 and 8 (representing Nux vom., the 12th and 30th dil.) were together concentrated by slow evaporation, slightly acidulated, and injected into the body of a frog weighing twenty-five grains, who was to all appearances not affected by it.

On the second day a solution containing $\frac{1}{20000}$th of a grain of Strychnine was injected into the same animal, which showed symptoms of poison in a few minutes, and on agitation was thrown into a violent spasm and died soon afterwards.

From the same data, as given in test No. 6, this would have

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been equal to the injection into the human subject of the active principle contained in $91\frac{1}{16}$ gallons of the solution contained in vials marked 7 and 8. Or if taken into the stomach, allowing the usually accepted ratio of 3 to 1, *equal to* 273 *gallons and* 24 *ounces.*

From the above experiments I am satisfied that the series contained no known principles of vegetable origin except alcohol.

Test No. 9.

No. 9 (representing Sulphur, 3d dil.) was tested according to the several methods for discovering unknown substances in solution, and slight traces of Sulphur were found. The contents of the whole bottle was then evaporated to dryness, treated with boiling Nitric acid, slightly diluted with water, and a solution of Chlorate of barium added, a faint white precipitate of Sulphate of barium was thrown down, barely discernible to the naked eye, but showing conclusively that Sulphur was the substance in solution.

Tests Nos. 10, 11, *and* 12.

Nos. 10, 11, and 12 (representing the 6th, 12th, and 30th dil.) were then similarly treated and gave no traces of Sulphur, containing only alcohol and water.

By the above method the presence of $\frac{1}{40000}$th part of a grain of Sulphur can be readily detected, and acid containing $\frac{1}{2000000}$th part of a grain of Sulphur will cloud the solution and show a distinct precipitate.

As before remarked, in each of the above experiments, which extended over a period of three months, new apparatus was used, and every possible precaution taken to prevent the introduction of foreign matter, and to secure accurate results.

Although the tests, as applied above, failed to discover any vegetable substances in the third dilutions, and no traces of minerals above the 3^x, I determined to push these experiments still further, and, if possible, not only to demonstrate their curative power, but to discover how much of a given substance would produce an *aggravation* of the symptoms.

My first case was one of continued "morning sickness;" the patient being unable to take even water without vomiting. Had

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been under allopathic treatment for six weeks, and abortion was recommended. I tried internally, Lactic acid, Ipecac., Sepia, and Nux moschata without perceptible change. Remembering that in test Nos. 6 and 7 the injection of the active principle of 2 ounces of Nux vom. 6^x dil. into a small frog produced no effect, and that this equalled the effect of 273 gallons and 24 ounces taken into the human stomach, I felt justified in adopting a new method. Procuring a new hypodermic syringe I carefully injected under the skin of the forearm ten drops of Ipecac., the 6^x dil. The effect was magical. In a few hours my patient was enabled to take food, and speedily recovered without even a repetition of the dose, or the slightest aggravation of the symptoms. Two eminently respectable homœopathic physicians of Louisville can *substantiate* the above statement.

Emboldened by the successful results in the above case I next injected ten drops of the 6^x dil. of Tartar emetic, in the case of a policeman suffering from a violent attack of asthma. The paroxysm was relieved in twenty minutes, and the patient enabled to lie down and sleep for the first time in three days. This was repeated four times, at long intervals, and the patient speedily recovered. At no one time did we discover the slightest aggravation of the symptoms following its use.

The next case was one of dysmenorrhœa, and the violent colic yielded in less than ten minutes to the hypodermic injection of ten drops of Pulsatilla 6^x dil. over the region of the uterus.

In more than fifty cases, where this plan of administering medicines was used, in not one single instance was there the slightest apparent medicinal aggravation, and although the dilutions were all used crude (that is, undiluted with water), in no case did the alcohol produce a sore, unless used in *fleshy* parts, and then in but very few cases.

The conclusions drawn from the above experiments have convinced me (had such been necessary) of the efficacy of dilutions above the 6th decimal, and that, although beyond the reach of the tests of chemistry, they still contain medicine enough to cure disease.

It has also convinced me that homœopathic medicines, hypodermically administered, are often of great value.

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It has strengthened my confidence in the administration of the single dose, *provided* that the dose be sufficient to at once control the conditions.

It has shaken my faith in so-called *aggravations* from homœopathic dilutions, above the 6th dil., and I am led to believe that this is a question but imperfectly understood; that the profession rely too much upon prejudices unsustained by facts.

It is my opinion that this *fanatical search* after *new attenuations*, implies a want of confidence in the material of the present. To say that the 30*th dil.* will cure where the 6*th dil.* will not, is to deny the truths discovered by Hahnemann. To say that it makes a *better* cure still implies a *doubt*. To say that it is because of medicinal aggravations, is to state what is not capable of verification.

Experiments with the different attenuations are legitimate; but as they in no wise affect the principles of homœopathy, we should, as far as possible, confine their scope within the boundary of well-established scientific methods. In our great work of reforming medicine we ought not to envelop the plain, simple, all-convincing truths—our powerful weapons—in a mystic, psychological halo, which is, to say the least of it, not properly understood by our own profession.

It retards our own progress and causes the scientific investigator to hesitate.

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REMARKS AND SUGGESTIONS CONCERNING CERTAIN HOMŒOPATHIC TRITURATIONS.

By J. Edwards Smith, M.D., Cleveland, Ohio.

It will be remembered that, at the last session of this Institute, held at Lake George, I had the honor of presenting a paper discussing, to some extent, the behavior of Aurum under the pestle, as developed by the process of trituration.

This paper, as presented, was simply a narration of a series of microscopic observations on various triturations of Aurum. It was accompanied by a series of explanatory drawings, made directly from the microscope, and by the aid of the camera-lucida.

Before leaving the Lake I had formed the determination to still further pursue these investigations, with the hope of eliminating any error existing in my past work, or perchance of arriving at new facts of interest to the profession.

During the vacation the study of the triturations has received all the attention that circumstances would permit; one drawback alone will here be mentioned, viz., my eyes will no longer bear the severe strain consequent on the protracted sitting to which they have so long been accustomed. Thus it has often occurred that my daily use of the microscope professionally was all, nay, even more than the state of my eyes would allow. Nevertheless, these microscopic, as well as other, observations, have, however, been made in the interim, some of which, at the date of this writing, are still occupying my attention, the results of which will be presented at a future session.

In laying out my work of the past season I determined to review carefully the ground covered by my original contribution to the Institute, desiring thereby either to confirm my past ob-

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servations, or, on the contrary, as I have already intimated, to expose any latent errors perchance therein contained. It is always more pleasant to discover one's own blunders than to accept the tender mercies of the critic.

Knowing full well the paramount importance of the proper illumination of an object under the microscope, especially when triturations of Aurum are examined, I have expended considerable time and study in this direction. I now have to report that the method of using the solar beam in connection with the use of the high-apertured objectives, suitably diaphragmed, as described by me at Lake George, I still find to give me results decidedly superior to all others I have tried, especially as to the *recognition* of gold.

This matter of the *recognition* of gold, during examinations of its triturations, is of the utmost and vital importance. It will be remembered that at the last session I pointed out the fatal errors likely to occur from the use of reflected light; nevertheless, it is to be noticed that, during the past year, one observer at least, engaged in the study of gold triturations, used this same reflected light constantly, to the almost exclusion of all other methods of illumination.

I have also reviewed that portion of my past work which was accompanied by the series of drawings executed by aid of the camera-lucida and microscope under amplifications of 1500 diameters; my object being, first, to ascertain whether certain infinitesimally small particles, which, under amplifications of 1500 diameters, were too dimly seen to be recognized as gold, or to be accurately measured, might not be, under higher powers; in which case to also measure the same as accurately as possible. In this work the chief instrumentation consisted of:

1st. A superb duplex immersion, one-tenth, by Tolles, balsam aperture of 100 degrees. This objective displays all the known tests, including the Fassolt 120,000th band of lines.

2d. A special micrometer stage-plate, ruled especially for me by Professor William A. Rogers, of Cambridge, Mass. This plate contains the standard American inch, and also the French centimeter. A horizontal line traverses this plate from right to left. Above this the standard inch lines are ruled, while below are

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the lines of the centimeter; both sets of lines contact the horizontal one, hence it occurs that the two sets of lines at the point of contact with the horizontal are seldom coincident, the one series forming "laps" with the other. Now by measuring these "laps" under the objective, and comparing the said measurements with their tabular values, we have the means of cross-questioning the accuracy of the rulings in the severest manner possible. The plate in question, under this close scrutiny, will always give me values true to three places, and often four places, of decimals. This plate is a marvel of mechanical skill.

3d. A Donald cobweb micrometer, fitted with one-fourth inch ocular, the value of the wheel divisions being determined by aid of the Rogers's stage-plate above mentioned.

4th. Tolles's achromatic amplifier. This instrument doubles the power of the objective and eye-piece, without disturbing the corrections of the objective.

5th. Tolles's patent one-half and one-fourth solid oculars.

6th. The new "Acme" stand, the joint production of Mr. John Sidle and myself. This stand combines all the latest improvements. For the close work contemplated the camera-lucida is not adapted, and was not used.

It will be remembered that my paper read at Lake George contained an account of Mr. Witte's new triturations of Aurum from the precipitate by phosphorus in ether. These, being so far superior to all others I have met with in point of fineness of the gold particles therein contained, were selected for the work in hand. Of these the 2d, 3d, and 6th decimal received my special attention. Further along I shall have occasion to again refer to these superior triturations.

The method of mounting the triturations was the same as that described last year, and the superiority of the method further demonstrated, as it seems to me, beyond a reasonable doubt.

I now proceed to give briefly the results of my observations over the new triturations of Mr. Witte, above mentioned.

These I have examined time after time, using the transmitted solar beam in conjunction with the diaphragmed objective, the greater portion of my time and attention being devoted to the 3d and 6th decimal triturations.

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With the objective in perfect adjustment, and by the most delicate manipulations of the illumination, I have discovered, under amplifications of 2000 diameters and upwards, certain exceedingly small particles which exhibit the characteristic behavior of gold. These minute particles, after increasing the amplifications to 4000 diameters and upwards, were carefully measured with the cobweb micrometer, and found to vary between $\frac{1}{95000}$ to $\frac{1}{115000}$ of an inch. The most diligent search, coupled with the most delicate manipulations, failed to display any smaller particles than the above named, having the slightest appearance of metallic gold.

I desire to call your attention to a fact, to which many of those before me can attest, viz.: At the last session of this Institute, at Lake George, the writer placed on record his utter disbelief as to the capacity of the microscope to determine the ultimate divisibility of matter. The question with the author from the outset has been, how far—to what extent—is the microscope of service in enabling us to study the behavior of drugs under the pestle during the processes of triturations.

Leaving then the item of ultimate divisibility out of consideration, the question arises, what has the microscope taught concerning our triturations; or, referring to my own investigations, what has the author learned from the microscope concerning triturations of Aurum, during the past two years, which were not previously known and accepted.

To this interrogatory I responded as follows:

First. A certain so-called trituration, labelled and sold for Aurum 3x, contained no gold at all.

Second. Mr. Witte's trituration of Aurum foliatum has been demonstrated to be almost equal in fineness of particles to the average triturations from the precipitate.

Third. Four-hour decimal triturations are not very far superior to two-hour triturations.

Fourth. Triturations of Aurum met., up to the 6x, from various makers, vary considerably; no two being identical in fineness of the contained particles.

Fifth. The popular idea that particles of gold are ten times smaller in the 2d decimal trituration, than in the 1st decimal, is

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very far from being correct. Nor are particles of gold in the 3x ten times smaller than in the 2d decimal trituration. These are plain facts and are easy of demonstration.

Sixth. In all the triturations of gold, from the 1st to the 6th decimal, examined by me, fully 33 per cent. of the metal escapes subdivision under the pestle, *i. e.*, does not become subdivided to anything like the extent formerly accepted.

Seventh. It is quite possible with careful manipulations to display particles of metallic gold under the microscope which, in point of minuteness, challenge our most difficult test-objects.

Among the most difficult test-objects known in modern microscopy may be quoted the finest bands, ruled by Professor Rodgers, of Cambridge, Mass., and Mr. Charles Fassolt, of Albany, N. Y. Either of these equal 120,000 lines to the inch. To display these delicate rulings the utmost delicacy of manipulation, coupled with the employment of modern objectives possessing exquisite definition, is imperatively demanded; furthermore, it may be asserted that few, even of the modern opticians, furnish object-glasses equal to the task.

The finest object-glasses capable of resolving the delicate tests above named are, and for the past eight years have been, made in the United States. The work of the veteran, Mr. Charles A. Spencer, of Geneva, N. Y., and that of Mr. R. B. Tolles, or Boston, Mass., is well known and appreciated, both at home and abroad. The late glasses of Zeiss, of Ger Denmark, are quite equal, in point of definition, to those of Spencer or of Tolles.

Exceedingly fine object-glasses have lately been produced by the Messrs. Bausch & Lomb, of Rochester, N. Y., and also by Messrs. Powell & Lealand, of London, England.

In giving, as above, the names of the several opticians whose objectives alone exhibit that exquisite definition rendering them successful to attack the most difficult problems, in the line of test-objects, known in microscopy, *i. e.*, the resolution of the Rodgers and the Fassolt 120,000th bands, the seeming digression may be pardonable, when it is taken into consideration that observers using object-glasses, known to be of inferior quality, sometimes claim results which would at sight be rejected by microscopic experts. One author, during the past year, claims to

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have seen particles of gold measuring but $\frac{1}{5000}$th of the m.m., $\frac{1}{127000}$th of the English inch, and this, too, with reflected sunlight. Comment is here unnecessary.

Returning to the enumeration of the results possibly accomplished by my own observations, I have now to call your attention to a most interesting and, it seems to me, important matter, which has been brought to light, and to a certain extent developed during my studies of the gold triturations.

Referring back again to my original paper, read at Lake George, many of those present will recollect that I exhibited a specimen of a new trituration of Aurum metallicum, prepared by Mr. L. H. Witte, pharmacist, of this city, to whom I am under great obligations for his valuable assistance from the commencement of my observations to the present date.

At our last session I was content with simply inviting your attention to the new preparations. You were shown that the 1st decimal trituration was very much darker, even approximating to the color of slate, as also that the 3d decimal trituration was even darker in color than the usual 1st trituration. Accompanying the statement that these new triturations of Mr. Witte's were prepared from gold thrown out of solution of the chloride by the addition of ether and phosphorus, I also asserted that the particles of gold thus thrown out of solution average smaller than those found in the usual 1st, 2d, and 3d decimal triturations.

On my return home, Mr. Witte, at my request, carried his new triturations up to the 14th decimal.

While engaged in the study of these last triturations, I had occasion to dissolve a small quantity in a little distilled water, and was astonished to find that the liquid instantly assumed a clear and almost transparent purple color; adding a little alcohol by way of preservative the purple fluid remained constant and unchanged for weeks and even months.

Now, if to a solution of the chloride of gold we add, as did Mr. Witte, a solution of ether in phosphorus, we shall obtain this same purple solution, which, when examined under the microscope, will be found to consist principally of metallic gold, and in a state of very fine subdivision.

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Having determined this fact it became desirable to recover this gold intact, and by some method render the process practicable to the homœopathic pharmacist.

To secure this desideratum Mr. Witte and myself devoted much time and attention, and to Mr. Witte belongs the honor of having discovered a process at once practicable as well as simple, and meeting the requirements of the pharmacist. This formula will be given in detail before concluding this paper.

If, after recovery, the gold be submitted to the process of trituration, and subsequently dissolved in water we have, as I have before stated, the original purple liquid again, that resulting from the trituration being obviously purer than that occurring from the addition of ether in phosphorus to the solution of the chloride.

If, after having dissolved a little of the trituration in water, adding alcohol, as before stated, and allowing the purple fluid to remain quiet, say for ten days, a light sediment will be noticed at the bottom of the vessel. By decanting now the supernatant purple liquid into a clean bottle no further sediment seems to form at least for weeks; here we have the purple liquid in its purest form.

As to the nature of the sediment referred to, I opine that it consists principally of the impurities contained in the sugar of milk, and perhaps of a small proportion of the larger particles of metallic gold. In this direction there is still room for further study.

If we attempt to dissolve too much of the trituration we may obviously expect a sediment.

The clear purple fluid, after a greater or lesser period, say from two to four months' time, will finally settle to the bottom, leaving the liquid above as clear as water. If, however, we shake the bottle slightly this precipitate disappears, and the purple fluid again makes its appearance.

Any attempt to examine the gold contained in the purple fluid in the wet state will fail. This is true of the usual test-objects used by advanced microscopists. By evaporating, however, a few drops on a glass slide the slide becomes gilded, having the appearance of watered silk described in my former paper.

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These new triturations present peculiar claims for your consideration.

1st. Their very much darker color. This to the professional pharmacist will be a matter of interest and likely to excite his attention, knowing full well that the finer the comminution of particles the darker will be the resulting color of the trituration.

2d. No previous trituration of gold will give the purple fluid when dissolved in water.

3d. The lower triturations, say the 1st and 2d, are easily demonstrated by the microscope to be far superior to previous triturations, and, be it known, that on the integrity of the low triturations rest that of all the higher ones.

I now proceed to dissolve samples of these new triturations in water, and will pass them around for your personal inspection (specimens prepared and passed to members). With these you will also receive a small sample of the 1st decimal trituration, dry, for your further examination at your leisure (samples of the trituration here given to members present).

The 5th decimal trituration dissolved in water will communicate to the latter a perceptible purple tinge. Experienced eyes, accustomed to judge of colors, might detect the color in the higher triturations.

The question now naturally arises, does this purple fluid contain gold in suspension or gold in true solution?

As proof that this gold is truly in a state of suspension the following experiment may be cited:

Resin dissolved in pure alcohol gives a perfectly clear and transparent liquid, which cannot be distinguished by the eye from alcohol without the resin. To this solution add water very carefully until the resin shall be *very slightly* thrown out of solution. If the experiment be conducted properly the resinous particles, in a finely divided state, will remain suspended in the liquid permanently, while the latter will exhibit a trace of color. We know now from obvious reasons that the resin is not in a state of solution.

Again, it is a well-known fact that certain solutions of silver are liable to turn red owing to the reduction of the metal in a finely comminuted state; the reduced silver being held in suspen-

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sion cannot be removed by filtering. If, however, to the liquid be added a suitable quantity of Kaolin, and the whole well shaken and immediately filtered, the reduced silver will be separated, the silver remaining on the filter, and in this manner it may be recovered.

Now, as may be hereafter seen, this shaking with Kaolin and subsequently filtering is a process practically identical with that adopted by Mr. Witte for the recovery of his gold.

I may here remark, *en passant*, that the superiority of gold, in point of fineness, precipitated from solutions of the chloride by phosphorus and ether, was clearly demonstrated by microscopic examinations, and hence the importance of recovering this gold for the purpose of subsequent triturations.

Furthermore, from the minute particles thus thrown out of solution by the action of ether and phosphorus, together with the presence of the purple color, may it not be urged that the metal is simply held in the vehicle in a state of true suspension?

In support of this position many natural phenomena may be cited, *e. g.*, the prevailing blue of the heavens, the green of the ocean wave, both owe their color to myriads of infinitesimal particles held in true suspension. The gorgeous tints seen on the feathers of the peacock depend on the close striation of particles. This latter fact is easy of demonstration under the microscope by separating the particles under a low power, whereupon the beautiful colors vanish, being replaced by a dingy brown.

Again, the fine bands of the microscopist's test-plates all show a characteristic color when examined by reflected light.

Nor are the results of my microscopic examinations of these new triturations such as would strengthen the hypothesis of the gold being in a state of true solution, for, in every instance, the *mass* of gold seen was not in particles smaller than $\frac{1}{60000}$th of an inch. The very finest particles alone were those measuring from $\frac{1}{95}$th to $\frac{1}{115000}$th of the inch.

Finally, as I have already stated, if we allow the purple fluid sufficient time the gold will eventually settle to the bottom of the vessel, leaving the supernatant liquid entirely devoid of color.

During the past few months samples of the new triturations

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have been sent to friends prominent in our profession for examination and study. The formula for their preparation has, however, been withheld for the purpose of presenting it to the Institute during its present session. Nearly all of those to whom the triturations have been forwarded seem to regard the gold as in a state of solution. A letter received by me, bearing date of June 2d, from a gentleman favorably known to all before me, contains the following paragraph:

"One thing, however, strikes me about this preparation, and that is, that it can hardly be said to be in suspension, but that it is truly in solution. According to chemical authority, Silliman, 'solution is the result of a feeble affinity, but one in which the properties of the dissolved body are unaltered;' and according to Henry, 'solution is a state of diffusion of the particles of a solid throughout a liquid, without destroying its transparency.' As your new preparation of gold comes fully under the conditions just quoted it will be considered as soluble, and not merely suspended. That, of course, will not affect the value of the discovery."

Other letters received during the past three months from intelligent and valued correspondents are similar in tenor to that just quoted.

Be the facts what they may, there will be plenty of time in the future to arrive at a verdict, and, after further deliberation and study. For the present I am content thus to leave the question open.

Of the superiority of these beautiful triturations there can be no manner of doubt. Furthermore, this marked improvement appeals with force to those using high as well as low potencies.

Is it probable that all the remaining triturations have reached the acme of perfection, and may there not be room for their further study and improvement?

In conclusion I desire to place on record my obligations to Mr. Witte for the valuable assistance he has rendered me during the entire progress of my investigations, and I feel assured that when his new triturations shall become better known that the profession will not be backward in their appreciation of his valuable discovery, which he gladly presents through this In-

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stitute to the profession at large. His formula is as follows, which I give in nearly his own words:

Sixteen grains of gold were dissolved in nitro-muriatic acid; to this solution sixteen pints of distilled water were added.

Six grains of phosphorus were dissolved in twelve fluid ounces of ether. The two solutions were mixed together.

The action of the phosphorus upon the chloride caused its reduction, there resulting phosphorus compounds and metallic gold, the gold in particles so fine as to remain in suspension and to pass through the filter-paper with facility.

To separate the gold a solution of albuminum chloride was first added, then aqua ammonia in excess. The action of the ammonia caused the formation of albuminum hydrate, which, when filtered out, retained the particles of gold. The bulk of the albuminum hydrate upon the filter was about one cubic inch.

The albuminum hydrate was now dissolved out with muriatic acid, the solution passing through the filter and leaving the gold, which was then thoroughly washed with alcohol to dissolve out any phosphorus, and then with distilled water until nothing but the pure gold in fine particles was left upon the filter. The gold thus remaining was subsequently submitted to the usual process of trituration.

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PROOFS OF DRUG PRESENCE AND POWER IN ATTENUATIONS ABOVE THE SIXTH DECIMAL,

AS FURNISHED BY THE SPECTROSCOPE.

By C. Wesselhœft, M.D., Boston, Mass.

This is the work allotted to me for the Bureau of Materia Medica, Pharmacy, and Provings. The problem appears large, and its solution seems to promise more than we shall actually be able to realize.

The spectroscope is, in the minds of many, a somewhat marvellous instrument, which is thought to reveal to us, not only hidden secrets, but also to afford direct proof of the infinite divisibility of matter.

Revelations to unaided senses, of extremely minute portions of matter, such as the odor of fragrant flowers perceived at a great distance, or the perception by the senses of infinitely minute quantities of metals, seems less marvellous than when revealed to us through the medium of some instrument, such as the spectroscope, or the transmission of words to a great distance by the telephone.

In order to arrive at a clearer understanding of what we may actually expect from the spectroscope, a brief sketch of its inception and progress is in place, and for this there is no better authority than Mr. Henry E. Roscoe's *Lectures on Spectrum Analysis.*

The first principle to be understood in this connection is that when light is allowed to fall through a prism against a screen, it will be perceived to have been separated into its component parts, and will appear split up into a band exhibiting the colors of the

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rainbow. This is the solar spectrum. None of the different colors allow of further splitting up into other colors, and each differs from the other in wave-length, and intensity of vibration.

Besides the visible rays of light, there are invisible rays, playing a most important part in the nature of solar light. The red rays produce the most heat; the yellow rays are the most luminous to the eye; while the blue and violet possess the greatest chemical action. (*Photography.*) The dark heating rays are invisible, but demonstrable by Tyndall's experiment with the ray-filter, a solution of Iodine in disulphide of Carbon, by which all the luminous rays can be filtered out, and only the invisible heating rays are transmitted, which is proved by the ignition of paper, heating of platinum, etc. The solar spectrum is not a gradual transition of one kind of light into another, but interspersed between the shades and in them are certain dark lines, to be regarded as shadows, or spaces where certain luminous rays are absent (L. C. Wollaston, *Philosophical Transactions*, 1802, p. 328). They are only obtainable by allowing the light to pass through a narrow slit. They are always the same in any kind of sunlight, direct or indirect, and their invariable position is known and carefully mapped out; because by knowing exactly the position of these dark lines in the solar spectrum, we can ascertain that iron, sodium, and other well-known substances exist in the solar atmosphere. This was discovered by Wollaston; they were first mapped out by Fraunhofer to the number of 576, in the year 1814, and are called after him.

Every chemical element, in a state of gas, when heated, gives off a peculiar light, so that the spectrum of every element in a state of glowing gas, is totally different from that of any solid body, inasmuch as, instead of a continuous spectrum, it presents a discontinuous one containing light bands or lines, indicative of the presence of the particular elementary gas in question.

Various bodies burned in a flame, *e. g.*, Lithium, Soda, or Potash, color the flame yellow and violet; Salts of strontium color the flame crimson; Barium green, etc., and each chemical substance can be detected by its peculiar light, when burned in any luminous flame like that of Bunsen's burner.

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Every chemical element has the property of emitting its peculiar light, if its vapor can be heated so as to become luminous.

Most of the alkaline earths can readily be detected by merely burning them in a sufficiently hot flame; but the spectroscope is the instrument by which very minute quantities of each substance can be detected. This instrument consists of a prism placed on a disk or platform; a telescope is fixed on one side of the disk, and is directed towards a surface of the prism. On the opposite side of the disk is placed a tube having a lens in the end directed toward the prism, and a narrow vertical slit in the other end directed towards the flame. This form of spectroscope with a simple lens will answer the purpose of detecting the minutest particle of most substances. More complicated instruments, showing two spectra from two flames, are in use; also spectroscopes with many prisms, which have the effect of not only showing colored bands in the spectra of various substances, but which by repeated refraction, split the simple colored bands into masses of bright lines, each one as fine as the most gauzy spider's web.

As each metal, salt, etc., produces bands of peculiar color, always occupying the same place in the spectrum, maps have been prepared of the spectra of various substances, showing the exact position, breadth, and intensity of the bright lines, enabling observers to identify the presence of known metals, and to recognize the presence of unknown elements. The advantage of this method of analysis consists in its delicacy, which greatly exceeds the most delicate tests of chemistry. The manner of using the instrument, is to place a drop of a solution to be tested upon a small loop of platinum wire, and to burn it in a Bunsen burner in front of the slit of the tube, while the observer looks through the telescope at the prism, in a dark chamber. If metals are to be observed which are not volatilized in an ordinary flame, they are made incandescent by means of the electric spark, a method more difficult of application than the former, both on account of the additional apparatus, as well as owing to the rapid action of the spark.

Instances of the Delicacy of Spectrum Analyses.—The most sensitive reaction is that for Sodium, the minutest particles of which, unless previously guarded against, disturb all other tests. So-

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dium is not only everywhere present, but soon returns if removed by heat, so that a thin platinum wire, if not used for a few minutes, will at once show the yellow sodium lines again, which must be removed when trying another substance on the same wire. $\frac{1}{300000}$th part of a milligram, or $\frac{1}{1800000}$th part of a grain can be easily detected. It is always present in the air, and all bodies exposed to the air show, when heated, the yellow soda line.

Lithium, $\frac{1}{100000}$th part of a milligram, or $\frac{1}{600000}$th part of a grain can be easily detected by its red lines. It was formerly known to exist in only four minerals. It is now found by spectrum analysis to be one of the most widely distributed elements. It exists in all rocks, in the ashes of most plants, in milk, human blood, and muscular tissue. *Strontium* is easily detected by red and blue bands, when only $\frac{6}{100000}$th of a milligram, or $\frac{1}{100000}$th of a grain is present. *Calcium*, $\frac{6}{100000}$th of a milligram, or $\frac{1}{100000}$th of a grain of lime can be easily detected. *Cæsium* and *Rubidium* were detected in the proportion of two hundred grains in forty tons of mineral water.

Thallium and *Indium* were discovered in a similar way. To illustrate the delicacy of the spectrum reaction, I transcribe the following: "The following experiment shows that the chemist possesses no reaction which in the slightest degree will bear comparison as regards delicacy with spectrum-analytical determination of Sodium. In a far corner of our experiment-room, the capacity of which was about sixty cubic centimeters, we burnt a mixture of three milligrams of Chloride of sodium with Milk-sugar, while the non-luminous, colorless flame of the lamp was observed through the slit of the telescope. Within a few minutes the flame, which gradually became pale yellow, gave a distinct Sodium line, which, after lasting ten minutes, gradually disappeared.

"From the weight of Sodium burned, and the capacity of the room, it is easy to calculate that in one part by weight of air there is suspended less than $\frac{1}{2000000}$th part of soda smoke, as the reaction can be observed with all possible comfort in one second, and as in this time the quantity of air, which is heated to ignition by the flame, is found, from the rate of issue, and from the

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composition of the gases of the flame, to be only about 50 cubic centimeters, or 0.0647 gram of air, containing less than $\frac{1}{20000000}$th of Sodium salts; it follows that the eye is able to detect with the greatest ease quantities of Sodium salt less than $\frac{1}{300000000}$th of a milligram in weight."*

The application to homœopathic pharmacy of the above observations is a very easy matter, and it appears at a glance that the quantities of matter observable by spectrum analysis, permitting the ocular perception of $\frac{1}{600000000}$th part of a grain of Lithium, or $\frac{1}{1800000000}$th part of a grain of Sodium, does not exceed the 4th centesimal or 7th decimal dilution. But it must not be supposed that because we fail, by the spectroscope, to see the presence of matter any further, that it is not present in many subsequent dilutions, nor that modern science does not allow us to calculate the limit to which soluble matter may be carried by progressive dilution. As I have shown in my last report to the Institute (*Transactions*, 1879), modern molecular science demonstrates that, in accordance with the average size of molecules, their number is calculable in a given quantity of water, or some other fluid, and such calculation is derived from the fact that a volume of substance, when reduced to a liquid form, is not much greater than the combined volume of its molecules.

According to this calculation the 11th centesimal, or 22d decimal dilution, would be the limit to which matter can possibly be carried, which is fully corroborated by Mr. Crooke's experiments on radiant matter. Hence, spectrum analysis is inadequate to demonstrate the extent of molecular divisibility to the senses.

In order to test the matter personally, I undertook the spectroscopic analysis of several substances (wherein I was assisted by Mr. Fletcher, Lecturer on Chemistry at the Boston University School of Medicine), at the Institute of Technology, where the use of instruments was most kindly placed at our disposal. I prepared decimal dilutions of Chloride of sodium and Sulphate of lithium as the two most available substances for analysis.

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* L. C., from Kirchhoff and Bunsen's first Memoir on Analysis by Spectrum Observ.—Phil. Mag., vol. xx, 1860.

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Each of these substances was diluted in distilled water in proportion of ten grains to one hundred drops of water, and carried up on this scale to the 8th decimal. The spectroscope was placed in a dark room; before its slit there was a Bunsen's burner, reinforced by atmospheric pressure to give a very intense flame.

Very thin platinum wires, melted into glass handles at one end, were bent into a little loop at the other end, just large enough to hold the fraction of a drop of the solution. Having burned off all the Sodium deposited by the atmosphere on the wire, it was then dipped into the 8th decimal dilution of salt, and held in the flame. This gave no spectrum with the characteristic yellow lines of sodium. These lines were faintly observed in a fraction of a drop of the 7th decimal, and very distinctly in dilutions below the 7th decimal.

Lithium sulphate was subjected to the same process, but showed no characteristic red lines above the 3d at these experiments; although a repetition, which I had no time to make, would undoubtedly have shown the presence of Lithium further, and I do not regard the last test as very conclusive.

But taking into consideration the more successful Sodium test, we find that the 7th decimal dilution contains the $\frac{1}{10000000}$th part of a grain. Each drop of the 7th decimal would contain $\frac{1}{10000000}$th of a grain, and when we consider that a minute fraction of a drop, perhaps only the tenth part, was burned in the flame, we must conclude that the test is one exceeding in fineness the one recorded by Bunsen and Kirchhoff, who say that $\frac{1}{100000000}$th is easily detected, while our fraction of about a hundred-millionth in the 7th decimal was only less easily seen, allowing a brief flash of yellow bands to become visible more nearly within the limits of the statement of those observers.

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PROOFS OF MEDICINAL PRESENCE AND POWER IN ATTENUATIONS ABOVE THE SIXTH DECIMAL,

FROM THE STANDPOINT OF THE PHYSIOLOGIST.

By Lewis Sherman, M.D., Milwaukee, Wis.

The determination of the limits of medicinal power in attenuations must be made by experiment. Observation and analogy connot give positive and unequivocal proof. They can, at best, give such indications as will point out the experiments which are necessary to this end. In observation the conditions are supplied by the natural course of events, and they have no designed reference to the question to be settled. In a perfect experiment, the conditions are designedly arranged so that only the force in question can determine the result. In searching for the limit of drug power in attenuation, three methods of experimentation have been pursued.

1. Experiments in which the provers took the medicinal preparations to be tested, and recorded all the sensations observed for several days or months afterwards.

2. Experiments in which the provers took Sugar of milk, and recorded all the sensations observed for several days or months afterwards.

3. Experiments in which the provers took the medicinal preparations at one time and the menstruum at another, without knowing, in any instance, which was the one and which was the other; and by close observation of their sensations tried to discover which was the medicinal preparation.

A typical example of the first of these three methods of experimentation is the "Reproving of Sepia," made under the

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direction of this bureau, published in the *Transactions of the Institute for the year* 1875. The chairman of the bureau, the late lamented Carroll Dunham, selected the subject and requested the professors of Materia Medica in the homœopathic medical colleges to organize classes of provers among the students.

Thirty provers were secured, and thirty-five provings were made.

Ten provings were made with the 3d centesimal trituration, *seventeen* provings with the 30th centesimal trituration, and *eight* provings with the 200th centesimal dilution. The ten provers of the 3d trituration recorded one hundred and ten symptoms, the seventeen provers of the 30th trituration two hundred and twenty-two symptoms, and the eight provers of the 200th dilution three hundred and four symptoms.

The first prover, an unmarried lady medical student, took five powders of Sepia 200th, and experienced during the following winter seven quarto pages of symptoms. The most prominent among these were tenderness of the mammæ, distress in the pelvis, great vascular excitement, a sensation as if the vulva were enlarged, frequent micturition. There were numerous and various pains, dull, dragging, pressing, throbbing, lancinating, shooting, darting, gnawing, and bearing down.

Once during the proving the menses came eight days ahead of time. This happened sixty-one days after the taking of the last dose of *Sepia* 200th, and only six days after taking a dose of *Nux vomica*, low. Yet the symptom forms a part of the pathogenesis of *Sepia*. The most remarkable symptom of all, perhaps a "keynote," was a mental one, "I recall known facts by association." This also occurred long after the taking of the last dose of *Sepia* 200th, and soon after the taking of a dose of *Nux vomica*, low. Nevertheless it is incorporated in Dr. Dunham's Hahnemannian arrangement of the symptoms, and forms a part of the recorded pathogenesis of *Sepia*.

The second prover, also a lady medical student, took two powders of *Sepia* 200th. She suffered great mental depression, and urinated quite freely, passing a very large quantity. She had very severe pelvic pains, and her mammæ were very sore. Like

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the first prover she felt very stupid during the whole lecture course, and had great difficulty in answering questions.

The symptoms lasted exactly one hundred and eleven days, and covered seven quarto pages of the *Transactions*. Their severity may be inferred from the fact that the word *very* occurs in the record more than seventy times.

Another prover, under the personal supervision of Dr. William Owens, of Cincinnati, Ohio, took a dose of *Sepia* 30^{c} at nine o'clock in the evening. At four o'clock the next morning she became alarmed at her condition and took a dose of *Aconitum*, 3d. Before night her feet gave forth a most offensive odor. This symptom is incorporated by Dr. Dunham in the arranged pathogenesis of *Sepia*. After nine days the prover took another dose of Sepia 30^{c}, followed in a few hours by a dose of *Aconitum* 3^{d}. Nine days later she observed a fine rash over the body, particularly about the bends of the elbows and knees, brought out by heat and caused to disappear by cold. This symptom is incorporated in the pathogenesis of *Sepia*.

Hungry symptomatologists assume that such provings as these represent the disease-producing powers of drugs. Careful students of drug-action believe that most, if not all, of the symptoms added to our Materia Medica from such sources are worthless, because they are not the effects of the drugs to which they are ascribed. They think that the *Sepia* had no influence in modifying the symptoms, which would have occurred if the provers had taken only Milk sugar or Alcohol under the supposition that it was a medicinal agent.

This difference of opinion suggested more complete experiments.

In 1877, two years later, Dr. Conrad Wesselhœft, chairman of this bureau, presented provings of Milk sugar. These, also, were made by medical students, and were, in every important respect, analogous to the *Sepia* provings referred to. The provers were sixteen in number, eleven male and five female.

They received from Dr. Wesselhœft packages of Sugar of milk, and took it, probably under the impression that it was a medicinal agent. At the end of six weeks, they brought forth an array of seven hundred and sixty-five symptoms, equal in se-

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verity to those which had been ascribed to the attenuations of *Sepia*. The record of the symptoms is published in the *Transactions*, occupying thirty-one pages of that volume. Summarizing the above, it appears that:

Sepia 3^c, Milk sugar, and fear produce, on an average, *eleven* symptoms to the prover.

Sepia 30^c, Milk sugar, and fear produce, on an average, *thirteen* symptoms to the prover.

Sepia 200^c, Alcohol, and fear produce, on an average, *thirty-eight* symptoms to the prover.

Milk sugar and fear alone produce, on an average, *forty-eight* symptoms to the prover.

For the sake of brevity, the term "fear" is here made to include the state of mental solicitude which so increases the sensibility of the prover as to cause him to observe conditions and sensations which ordinarily would receive no more than a passing notice. This *fear* is a potent factor in the production of symptoms in all provings like those I have mentioned. Its power varies in different individuals, and in the same individual at different times. The influence of this factor must be eliminated from the provings in order to ascertain the effects produced by the drug itself. To eliminate, we must either remove or neutralize. Since we cannot remove we must neutralize. In the third, or test method of experimentation, this end is accomplished. The prover is deprived of all bias or prejudice, in his experiments, by being kept in ignorance as to whether, in any particular instance, he is taking a medicinal preparation or a blank containing the menstruum alone. Since he is just as likely to ascribe irrelevant sensations to the blank as to the medicine, these sensations cannot influence the result. He is thus delivered from the besetting snares which impede all experimenters upon attenuated medicines, who follow the ordinary methods. A typical example of the test method is seen in a series of experiments performed in the year 1879 for the *Milwaukee Academy of Medicine*, by the believers in the medicinal power of the 30th dilutions.

The experiments were designed as a crucial test of the efficacy or inertness of the 30th dilutions.

The plan was proposed in a paper which I read before that

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society in 1878. It was briefly as follows: Several vials, similar in appearance, were given to the prover. One of the vials contained the 30th centesimal attenuation of a remedy selected by the prover, while the remainder of the vials contained only a quantity of the menstruum in which the drug was prepared, namely, alcohol and cane-sugar. The prover undertook to select the medicine from among the blanks, by means of its effects upon the human organism.

The attenuations were made by the *Milwaukee Academy of Medicine* especially for the purposes of this test. The tinctures of plants and the 6th decimal attenuations of drugs, were obtained from well-known and reputable homœopathic pharmacists, and, in all cases in which the nature of the substances admitted, these original preparations were tested by members of the society to make sure of their genuineness. All of the attenuations were made at the meetings of the society, both believers and unbelievers in the 30th potency being present and witnessing the process. The vials were scrupulously clean and the Alcohol and sugar globules the purest obtainable. The attenuations were made by dilution and succussion, according to Hahnemann's directions, in the proportion of one to ninety-nine, and ten vigorous shakes were given at each dilution.

The attenuations thus prepared, together with the remainder of the Alcohol used in making them, and a sufficient quantity of labelled vials, sugar globules, and mailing boxes, were given to an unprejudiced layman of unimpeachable honor, who promised to guard them and dispense them as they were called for through the secretary of the society.

The chosen depositary was Rev. George T. Ladd, late pastor of the *Spring Street Congregational Church* in Milwaukee, now Professor of Mental Philosophy at *Bowdoin College*, Maine, and lecturer at *Andover Theological Seminary*. He is a man well known among the scholars in the church to which he belongs, and one who has borne an unblemished reputation in the communities where he has resided, and more important than all, a man who had no interests to serve in the matter except those of truth and honor. Rev. George T. Ladd took the preparations and utensils directly from the hands of the society and, himself,

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medicated the pellets and dispensed to the prover the test packages. The vials were all numbered and a record was kept of their contents.

The test packages were given out at various times, as they were called for, from January 13th to July 28th, 1879. Notice was given, at the beginning, of the time allowed for the experiment, and all the provers were notified a second time when the reports were due. January 26th, 1880, Professor Ladd mailed his report to the society. As soon as practicable thereafter the society met, broke the seals and compared the report of the depositary with the reports of the experimenters.

The result is indicated in tabular form thus:

TESTS OF THE THIRTIETH CENTESIMAL DILUTION.

W. H. Blakely, Bowling Green, Ky.,	Aconitum,	9*	Incorrect selection.
G. R. Mitchell, Richland Centre, Wis.,	Aconitum,	9	Incorrect selection.
C. R. Muzzy, Watertown, Wis.,	Aconitum,	9	Incorrect selection.
A. W. Woodward, Chicago, Ill.,	Aconitum,	9	Incorrect selection.
N. A. Pennoyer, Kenosha, Wis.,	Aconitum,	9	Incorrect selection.
M. A. Ries, Milwaukee, Wis.,	Aconitum,	9	Incorrect selection.
A. Uhlemeyer, St. Louis, Mo.,	Aconitum,	9	Incorrect selection.
J. H. Thompson, New York,	Aconitum,	9	No selection.
W. F. Morgan, Leavenworth, Kan.,	Aconitum,	9	No selection.
J. W. Thompson, Greenfield, Mass.,	Aconitum,	9	No report.
H. L. Waldo, West Troy, N. Y.,	Aconitum,	9	No report.
E. Lippincott, Bowling Green, Ky.,	Aconitum,	9	No report.
W. B. Trites, Manayunk, Pa.,	Aconitum,	9	No report.
C. H. Hall, Madison, Wis.,	Aconitum,	9	No report.
O. W. Smith, Union Springs, N. Y.,	Aconitum,	9	No report.
W. Colleson, St. Louis, Mo.,	Aconitum,	9	No report.
W. Eggert, Indianapolis, Ind.,	Aconitum,	9	No report.
H. A. Foster, Buffalo, N. Y.,	Aconitum,	9	No report.
T. L. Brown, Binghamton, N. Y.,	Aconitum,	9	No report.
H. A. Foster, Buffalo, N. Y.,	Arsenicum,	9	No report.
C. W. Mohr, Philadelphia, Pa.,	Belladonna,	9	No report.
J. A. Pearsall, Saratoga, N. Y.,	Belladonna,	9	No report.
E. C. Morrill, Norwalk, O.,	Nux vomica,	9	No report.
T. M. Martin, Delavan, Wis.,	Nux vomica,	9	No report.
N. A. Pennoyer, Kenosha, Wis.,	Arsenicum,	4	No report.
W. M. Butler, Middletown, N. Y.,	Digitalis,	1	No report.
C. B. Gatchell, Ann Arbor, Mich.,	Aurum,	1	No report.
C. B. Gatchell, Ann Arbor, Mich.,	Arsenicum,	1	No report.
C. B. Gatchell, Ann Arbor, Mich.,	Calcarea carb.,	1	No report.
C. B. Gatchell, Ann Arbor, Mich.,	Carbo veg.,	1	No report.
C. B. Gatchell, Ann Arbor, Mich.,	Sulphur,	1	No report.
W. S. Gillett, Fox Lake, Wis.,	Arsenicum,	1	No report.

* This column gives the number of "blanks" in each case.

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W. S. Gillett, Fox Lake, Wis.,	Aurum,	1*	No report.
W. S. Gillett, Fox Lake, Wis.,	Calcarea carb.,	1	No report.
W. S. Gillett, Fox Lake, Wis.,	Carbo veg.,	1	No report.
W. S. Gillett, Fox Lake, Wis.,	Sulphur,	1	No report.
O. W. Smith, Union Springs, N. Y.,	Arsenicum,	1	No report.
O. W. Smith, Union Springs, N. Y.,	Aurum,	1	No report.
O. W. Smith, Union Springs, N. Y.,	Calcarea carb.,	1	No report.
O. W. Smith, Union Springs, N. Y.,	Carbo veg.,	1	No report.
O. W. Smith, Union Springs, N. Y.,	Sulphur,	1	No report.
A. Uhlemeyer, St. Louis, Mo.,	Arsenicum,	1	*Correct* selection.
A. Uhlemeyer, St. Louis, Mo.,	Aurum,	1	No report.
A. Uhlemeyer, St. Louis, Mo.,	Calcarea carb.,	1	No report.
A. Uhlemeyer, St. Louis, Mo.,	Carbo veg.,	1	No report.
A. Uhlemeyer, St. Louis, Mo.,	Sulphur,	1	No report.
W. F. Morgan, Leavenworth, Kan.,	Arsenicum,	1	No report.
W. F. Morgan, Leavenworth, Kan.,	Aurum,	1	No report.
W. F. Morgan, Leavenworth, Kan.,	Calcarea carb.,	1	No report.
W. F. Morgan, Leavenworth, Kan.,	Carbo veg.,	1	No report.
W. F. Morgan, Leavenworth, Kan.,	Sulphur,	1	No report.
O. S. Childs, Beaver Dam, Wis.,	Arsenicum,	1	No report.
O. S. Childs, Beaver Dam, Wis.,	Aurum,	1	No report.
O. S. Childs, Beaver Dam, Wis.,	Calcarea carb.,	1	No report.
O. S. Childs, Beaver Dam, Wis.,	Carbo veg.,	1	No report.
O. S. Childs, Beaver Dam, Wis.,	Sulphur,	1	No report.
W. Colleson, St. Louis, Mo.,	Arsenicum,	1	No report.
W. Colleson, St. Louis, Mo.,	Aurum,	1	No report.
W. Colleson, St. Louis, Mo.,	Calcarea carb.,	1	No report.
W. Colleson, St. Louis, Mo.,	Carbo veg.,	1	No report.
W. Colleson, St. Louis, Mo.,	Sulphur,	1	No report.
Petrus Nelson, Minneapolis, Minn.,	Arsenicum,	1	No report.
Petrus Nelson, Minneapolis, Minn.,	Aurum,	1	No report.
Petrus Nelson, Minneapolis, Minn.,	Calcarea carb.,	1	No report.
Petrus Nelson, Minneapolis, Minn.,	Carbo veg.,	1	No report.
Petrus Nelson, Minneapolis, Minn.,	Sulphur,	1	No report.
L. A. Campbell, Attleboro, Mass.,	Arsenicum,	1	No report.
L. A. Campbell, Attleboro, Mass.,	Aurum,	1	No report.
L. A. Campbell, Attleboro, Mass.,	Calcarea carb.,	1	No report.
L. A. Campbell, Attleboro, Mass.,	Carbo veg.,	1	No report.
L. A. Campbell, Attleboro, Mass.,	Sulphur,	1	No report.

SUMMARY.

Ten-vial Test.

Number making reports,	9
Number making correct selection,	0
Number making no selection,	2
Number making incorrect selection,	7
Number making no report,	16
Total,	25

Five-vial Test.

Number making report,	0
Number making no report,	1
Total,	1

* This column gives the number of "blanks" in each case.

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Two-vial Test.

Number making report,	1
Number making correct selection,	1
Number making no report,	46
Total,	48
Total number of tests,	78
Total number of correct selections,	1

The most remarkable feature of the result, aside from the total failure in all of the ten-vial tests which were performed, is the fact that the majority of the experimenters did not venture upon a selection. This, with the fact that comparatively few of the advocates of potentization were willing to undertake the experiment, shows a lack of confidence in potentized drugs, which was not anticipated by the proposer of the test.

If the entire body of provers of, and healers with, dynamized medicines, cannot, in the course of twelve months, distinguish one of their remedies from its inert menstruum, under conditions which preclude the aid of collusion, fraud, or chance, it may be reasonably inferred that the so-called dynamized drugs are not to be relied on as medicinal agents. There is no evidence, in the results of this test that, the 30th dilution of any medicine contains any power or property which is not also contained in the menstruum in which the medicine is prepared. The nature and conditions of the experiments were such, that if there be in these dilutions any medicinal power, which can be recognized or handled, this power would have shown its existence by its effects.

It must be borne in mind,

(1.) That the genuiueness of the preparations is vouched for by competent physicians who were believers in the powers of the 30th dilutions.

(2.) That the custody and distribution of the preparations was put directly into the hands of a man of known integrity, who had no interest in the success or failure of the doctrine of dynamization.

(3.) That the experimenters were believers in the efficacy of preparations they tested.

(4.) That the experimenters chose the remedies with which they experimented and voluntarily undertook the task of selection.

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(5.) That the experimenters were not limited to any special method of investigation, but were allowed full liberty to apply chemical, electrical, physiological, therapeutic, or any other tests by which they might detect a difference between the medicated and the unmedicated pills. In view of these considerations the failures to report are significant.

The advocates of dynamization have plead that the test was too hard, avowing their belief that it is impossible also to select under similar conditions the 3d, 4th, 5th, and 6th decimal attenuations.

Partly to prove the weakness of this plea, but more especially to furnish *data* for determining the limit of drug power in attenuation, a series of experiments on the lower attenuations has been performed during the past year under the auspices of this bureau.

It was arranged that Dr. T. F. Allen, my confrère in this section of the bureau, should undertake a test of the 30th dilutions, similar to that of the Milwaukee Academy, while I undertook tests of the lower attenuations on the same conditions. A committee of three were to be appointed to oversee and place safeguards around each subseries of experiments. On each committee there was to be a representative of the American Institute of Homœopathy, appointed by Dr. Dake, the chairman of the bureau; a representative of the believers in dynamization, appointed by Dr. Allen; and a representative of unbelievers in dynamization, appointed by me. The committee to oversee Dr. Allen's tests was chosen as follows:

Egbert Guernsey, M.D., of New York, by Dr. Dake; J. T. O'Conner, M.D., of New York, by Dr. Allen; C. F. Chandler, M.D., of New York, by Dr. Sherman.

Awaiting the appointment of a similar committee to oversee my tests in Milwaukee, I learned that Dr. Allen had declined to go on with his experiments, and that he would not appoint a representative in the Milwaukee committee.

Knowing well the fertility of any tests of this sort which were not satisfactory to skeptics, I had insisted upon both Dr. Allen's tests and mine being surrounded by safeguards imposed by a committee representing believers and unbelievers. The absurdity

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of attempting to convince skeptics without giving them a representation in the safeguards is apparent to the wayfaring man.

After Dr. Allen's failure, I called upon the three medical societies of Milwaukee to appoint each its representative, of various opinions on the dose question, to scrutinize and place safeguards around the proposed tests. Dr. W. J. Hawkes, of Chicago, who had publicly challenged a comparative test of the 3d and 30th dilutions, was also requested to appoint a representative.

After considerable delay, occasioned mainly by the apparent unwillingness of the dynamizationists to aid in any tests, the arrangement of safeguards was completed and the experiments were begun.

The following record of the tests was made by the committee in an official manner.

RECORD OF A TEST OF THE LOW DILUTIONS.

Milwaukee, Wis., January 14th, 1880.—At 8 P.M. the following named gentlemen met in the office of Dr. Sherman on Wisconsin Street, namely:

Dr. Lewis Sherman, member of the *Bureau of Materia Medica, Pharmacy, and Provings, American Institute of Homœopathy.* Dr. C. C. Olmsted, appointed by the Chairman of the *Bureau of Materia Medica, Pharmacy, and Provings, American Institute of Homœopathy,* to represent the believers in high potencies in placing safeguards around the test.

Dr. G. C. McDermott, Dr. Samuel Potter, representing the *Milwaukee Academy of Medicine,* by special appointment.

Dr. E. F. Storke, Secretary, *Wisconsin State Homœopathic Medical Society.*

Professor George W. Peckham, teacher of biology, *Milwaukee High School.*

Absent, Dr. E. M. Rosenkrans, of the committee, appointed by the *Milwaukee Academy of Medicine.*

The committee was called to order by Dr. Sherman, Professor George W. Peckham was chosen chairman, and Dr. Samuel Potter, secretary.

Dr. Storke presented a sealed package with the following writing upon it:

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"I hereby certify that the contents of this box, consisting of a piece of *Phosphorus*, one seed of *Nux vomica*, one small bottle with *Mercury*, and one with *Arsenious acid*, have been examined by me, and I found them pure and as represented; and further, that I have placed them in this box, and have wrapped them up and sealed.

"GUSTAVUS BODE,
"MILWAUKEE, January 13th, 1880." Analytical Chemist.

The package was opened by Dr. C. C. Olmsted in the presence of the committee, and the substances enumerated above were found therein, each in a separate package. They were then placed upon a small table surrounded by the committee.

On motion, it was agreed that each member record his opinion regarding the medicinal efficacy of attenuated drugs, for the purpose of showing that all sides of the question are represented on this committee.

The chairman, Professor Peckham, stated that he had no opinion to express on the matter, not having had sufficient evidence before him to determine the question.

Dr. C. C. Olmsted stated that he believed in the medicinal efficacy of the drugs enumerated as high as the 200th decimal attenuation.

Dr. G. C. McDermott stated that he had the fullest confidence in the medicinal virtue of all drugs in the highest attenuations when attenuated by the Hahnemannian process.

Dr. Lewis Sherman stated that he had confidence in the medicinal efficacy of the drugs enumerated as high as the 6th decimal attenuation.

Drs. E. F. Storke and Samuel Potter stated that they had little or no confidence in the medicinal efficacy of the attenuation above the 6th decimal of the drugs enumerated.

Professor Peckham dissolved two grains of Arsenious acid with 200 minims of distilled water in a new clean test-tube.

At 9.15 P.M. Dr. Storke took his departure.

This solution of Arsenicum was then attenuated according to the Hahnemannian process to the 7th decimal by Drs. Olmsted

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and Potter. The preparations were dispensed for proving in the following manner:

Ten two-drachm vials were labelled "Arsenicum 6^{x}," and on each label was written a different number; the numbers running from one to ten, inclusive.

Ten slips of paper were likewise numbered from one to ten. Each of the slips was carefully folded to conceal its number, and was placed alongside the cork in the correspondingly numbered vial. Each of the vials was then wrapped in a square piece of white paper (the pieces of the same size and quality), so as to leave only the cork, one end of the slip, and the rim of the vial visible. The ten vials were then placed in a hat and shaken. Dr. Olmsted then took one vial from the hat, took out the cork and the slip, filled the vial with the Arsenicum 6^{x}, replaced the cork, deposited the filled vial in another hat, marked the slip which he took out "Arsenicum 6^{x}," and deposited it unopened in a paper slide-box. The other nine vials were then filled with distilled water by members of the committee; each slip being handed without being unfolded, or the wrapper being removed from the vial, to Dr. Olmsted, who deposited it in the box with the marked slip, and sealed the box; all the members of the committee writing their names across the seals. The ten vials thus deposited in the hat were again mixed up by shaking and taken from the hat.

The set of *Arsenicum* 6^{x} was then, in accordance with his request, handed to Dr. G. C. McDermott for experimentation, and the whole lot of material (drugs, water, alcohol, slide-box, etc.) was placed in a desk, the same being locked and sealed, the seals being signed by Dr. Olmsted and Professor Peckham; whereupon the committee adjourned to meet at the call of Dr. Lewis Sherman.

January 22d, 1880, 8.30 P.M. The committee met at Dr. Sherman's office. Present: Professor George W. Peckham, Chairman, Dr. Samuel Potter, Secretary, Drs. E. M. Rosenkrans (of the committee of the Milwaukee Academy of Medicine), C. C. Olmsted, and Lewis Sherman.

Dr. G. C. McDermott, having been called to the chair of Oph-

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thalmology and Otology at Pulte Medical College, had left the city.

Dr. Sherman dissolved four (4) grains of Phosphorus in a boiling flask in 2800 minims of Alcohol, in the view of the committee.

A package of Belladonna tincture, bearing the original seal of a well-known European pharmacist, was opened by the committee, and a portion thereof was attenuated to the 7th decimal dilution by Drs. Olmsted and Rosenkrans. A set each of Belladonna 3^x and 7^x were then dispensed by Drs. Olmsted and Potter in the manner heretofore described, the boxes of slips sealed, and the packages handed to Dr. Lewis Sherman for experimentation. The material was then placed in the sealed desk, as heretofore described, and the committee adjourned.

February 26th, 1880, 8.30 P.M. The committee met. Present: Drs. Rosenkrans, Olmsted, Sherman, and Potter. Professor George W. Peckham having promised to be present, but failed. The desk-seals were examined. One was found intact, the others having burst in drying. Arsenicum 5^x, 6^x, and 7^x were then dispensed by the committee in the manner heretofore described, Dr. Olmsted doing the medicating, marking, filling, and sealing of the boxes containing the slips. They were then handed for experimentation as follows:

Ars. 5^x and 6^x to Dr. Lewis Sherman.

Ars. 7^x to Dr. Samuel Potter.

After placing the material under seal in the desk, the committee adjourned.

March 16th, 1880, 8.50 P.M. The committee met. Present: Drs. Sherman, Olmsted, Rosenkrans, and Potter. Aconitum 3^x and 6^x were prepared from the tincture found in stock in Dr. Sherman's pharmacy. Phosphorus 5^x and 6^x were made from the solution prepared by the committee and kept under seal. They were then dispensed as follows, in the manner heretofore described: the filling, marking, and sealing being done by Dr. C. C. Olmsted in person, or under his immediate direction, by different members of the committee. To Dr. Potter were handed

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sets of Aconitum 3^x and 6^x, Phosphorus 5^x and 6^x. To Dr. Sherman sets of Aconitum 3^x and 6^x, Phosphorus 5^x and 6^x.

The material being placed under seal as before, the committee adjourned.

March 25th, 1880, at 8.30 P.M. The committee met. There were present Drs. Olmsted, Rosenkrans, Sherman, and Potter. Dr. Olmsted received the reports of Drs. Sherman and Potter. The boxes containing the marked slips were then examined by the committee, and with their seals were found intact. They were then opened by Dr. Olmsted, and the marked slips found to agree with the reports as follows:

Preparation tested.	NUMBER OF THE MEDICATED VIAL.			
	Dr. Potter's report.	Dr. Sherman's report.	Record in sealed box.	
Aconitum, 3^x	1	1	1	
Aconitum, 6^x	1	1	1	
Arsenicum, 5^x		6	6	
Arsenicum, 6^x		9	9	
Arsenicum, 7^x	6		6	
Belladonna, 3^x (1)		1	8	
Belladonna, 7^x (1)		2	9	
Phosphorus, 5^x	1	1	1	
Phosphorus, 6^x	7	7	7	

The committee then adjourned.

March 30th, 1880. The committee met at Dr. Sherman's office. There were present Dr. Lewis Sherman, Dr. C. C. Olmsted, Dr. E. M. Rosenkrans, and Dr. Samuel Potter.

The minutes of the previous meetings were read and approved.

Belladonna 3^x and 6^x, Phosphorus 8^x, 9^x, and 10^x were then prepared as before, from the tinctures—the Belladonna from a new tincture—and were dispensed by Dr. C. C. Olmsted in ten-vial sets, as heretofore described. They were handed out as follows: To Dr. Potter, Belladonna 6^x, Phosphorus 9^x, and to Dr. Sherman, Belladonna 3^x, and Phosphorus 8^x and 10^x.

After sealing the sealed boxes in the desk drawer heretofore used, the committee adjourned.

April 25th, 1880. The committee met. There were present Drs. Olmsted, Rosenkrans, Sherman, and Potter.

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Dr. Olmsted received the reports of Drs. Sherman and Potter, who also stated that they had each, before experimentation, divided with each other the medicines given to them by the committee. The boxes containing the marked slips were then examined by the committee, and with their seals were found intact. They were then opened by Dr. Olmsted, and the marked slips found to agree with the reports received, as follows:

Preparation.	NUMBER OF THE MEDICATED VIAL.			
	Dr. Potter's report.	Dr. Sherman's report.	Record in sealed box.	
Belladonna, 3^x (2).....	2	2	2	
Belladonna, 6^x (2).....	9	1	9	
Phosphorus, 8^x.....	5	7	7	
Phosphorus, 9^x.....	5	2	5	
Phosphorus, 10^x.....	4	10	1	

SUMMARY.

Both experimenters were successful with Acon. 3^x, Acon. 6^x, Arsen. 5^x, Arsen. 6^x, Arsen. 7^x, Bell. 3^x, No. 2, Phos. 5^x and Phos. 6^x.

Both experimenters failed with Phos. 10^x.

One experimenter succeeded and one failed with Bell. 6^x, No. 2, Phos. 8^x, and Phos. 9^x.

One experimenter failed with Bell. 3^x, No. 1, and Bell. 7^x, No. 1.

The committee then adjourned.

GEORGE W. PECKHAM,
Chairman.
C. C. OLMSTED, M.D.,
EUGENE F. STORK, M.D.,
LEWIS SHERMAN, A.M., M.D.,
E. M. ROSENKRANS, M.D.,
SAMUEL POTTER, M.D.,
Secretary.

For convenient reference I have arranged the preceding reports so as to make them correspond with that on the 30th dilution, by the Milwaukee Academy of Medicine.

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TESTS OF THIRD DECIMAL DILUTION.

Samuel Potter,	Aconitum,	9*	Correct selection.
Lewis Sherman,	Aconitum,	9	Correct selection.
Lewis Sherman,	Belladonna No. 1,	9	Incorrect selection.
Samuel Potter,	Belladonna No. 2,	9	Correct selection.
Lewis Sherman,	Belladonna No. 2,	9	Correct selection.

TESTS OF THE FIFTH DECIMAL DILUTION.

Lewis Sherman,	Arsenicum,	9	Correct selection.
Samuel Potter,	Phosphorus,	9	Correct selection.
Lewis Sherman,	Phosphorus,	9	Correct selection.

TESTS OF THE SIXTH DECIMAL DILUTION.

Samuel Potter,	Aconitum,	9	Correct selection.
Lewis Sherman,	Aconitum,	9	Correct selection.
Lewis Sherman,	Arsenicum,	9	Correct selection.
Samuel Potter,	Phosphorus,	9	Correct selection.
Lewis Sherman,	Phosphorus,	9	Correct selection.
Samuel Potter,	Belladonna No. 2,	9	Correct selection.
Lewis Sherman,	Belladonna No. 2,	9	Incorrect selection.
G. C. McDermott,	Arsenicum,	9	Lost the package.

TESTS OF THE SEVENTH DECIMAL DILUTION.

Samuel Potter,	Arsenicum,	9	Correct selection.
Lewis Sherman,	Belladonna No. 1,	9	Incorrect selection.

TESTS OF THE EIGHTH DECIMAL DILUTION.

Samuel Potter,	Phosphorus,	9	Incorrect selection.
Lewis Sherman,	Phosphorus,	9	Correct selection.

TESTS OF THE NINTH DECIMAL DILUTION.

Samuel Potter,	Phosphorus,	9	Correct selection.
Lewis Sherman,	Phosphorus,	9	Incorrect selection.

TESTS OF THE TENTH DECIMAL DILUTION.

Samuel Potter,	Phosphorus,	9	Incorrect selection.
Lewis Sherman,	Phosphorus,	9	Incorrect selection.

With a single exception there were no failures to report in the low dilution tests. The following note from Dr. McDermott to the Secretary of the Committee explains the absence of his name in the table:

CINCINNATI, OHIO, April 30th, 1880.

DEAR DOCTOR POTTER: In reply to yours of inquiry regarding the test, I am sorry not to be able to report even trying to find the medicated preparation. If you remember, it was just two days before I took my departure, and the medicines were mislaid, as I was not there during the moving. I regret sincerely the accident.

Ever yours,

G. C. McDERMOTT.

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* This column gives the number of "blanks" in each case.

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Reports of cures have been presented in evidence of the presence and power of drugs, in attenuations beyond the accepted limits of the divisibility of matter. This supposed evidence does not come in the form of statistics, comparing the effects of these attenuations with the effects of pure sugar, used in the same manner; and under the same conditions, as the supposed remedial agents. For this reason, these observations must go for nought. It has been shown by experiment that symptoms, similar to those obtained in the provings of the "dynamized" drugs, follow the administration of milk-sugar, and it may be shown by experiment that as remarkable recoveries from sickness will follow the use of sugar, as can be obtained from "dynamized" drugs. The results obtained in the tests of the *Milwaukee Academy*, by the believers in dynamization, point unmistakably to such a demonstration.

The evidence is not all in, until the sugar has had a fair trial. This much can be affirmed, that, in the competitive trials which have been made with dynamized drugs and pure sugar, no difference could be detected.

In conclusion, I submit an estimate of the probability of the existence of medicinal power in the attenuations tested, based upon the results of the experiments which have been made and presented:

3x	dilution,	2222	in favor to	1	against
5x	"	999	"	1	"
6x	"	158,730	"	1	"
7x	"	4½	"	1	"
8x	"	4½	"	1	"
9x	"	4½	"	1	"
10x	"	1	"	4½	"
30x	"	1	"	7,036,875,000,000,000,000,000,000,000,000,000,000,	against,

or leaving out of the calculation the experimenters who did not report 1 in favor to 1,999,999,999 against.

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THE PROOFS OF DRUG PRESENCE AND POWER IN ATTENUATIONS ABOVE THE SIXTH DECIMAL,

AS FURNISHED BY ANALOGY FROM THE FIELD OF IMPALPABLE MORBIFIC AGENCIES.

By J. P. Dake, M.D., Nashville.

If a drop of blood, or a particle of pus, or a breath of air, in which chemical tests and the spectroscope and the microscope can detect no impurity, is found, by human experience, to hold the seeds of disease, analogy warrants the conclusion that, in drug attenuations where such tests and appliances fail to discover a drug atom, there yet may be medicinal presence and power.

The field of morbific agencies is very broad, and, for the most part, covered with thick darkness. Human vision has discerned much in it by occasional gleams of light in efforts to learn the origin and to trace the history of various diseases.

Inheritance.—In the ovum and the seminal fluid are borne, from parent to offspring, those material yet impalpable seeds which, germinating in after years, give rise to *tuberculosis, carcinosis,* the *hydra-headed syphilis,* and other affections which are regarded as hereditary. No species of test, no means of diagnosis have yet been able to detect those seeds in advance of their germination and fruitage; and yet, where is the pathologist who ventures to deny their existence?

Parasites.—In articles of food and drink, in clothing, in beds, and in contact with persons diseased, various germs are received, which increase or develop into parasites—*epizoa, entozoa*—to prey upon and even destroy the human body. Some of these germs have been clearly seen and studied by direct observation,

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while others have eluded the keenest search with means the most perfect and powerful.

Judging the unseen by that which is seen ætiology has come to acknowledge the presence and sick-making power of living germs which no microscope has discerned.

Vegetable Emanations.—There are trees and plants the emanations from which occasion sickness and even death. There are persons who cannot ride along a road, beside which grows the *Rhus toxicodendron*, without having vesicular erysipelas, especially if the wind chance to blow from the direction of that shrub. The senses all fail to detect the poison thus borne upon the air. It is impalpable, yet who denies its potency?

Miasmata.—There are localities where one night's sojourn, where one hour's travel, may occasion intermittent fever, malarial fever, and other affections which we denominate miasmatic.

Whatever may be our views of the pathology of such affections—whatever organ or tissue we may regard as the one primarily or chiefly affected—we cannot escape the conclusion that in such localities there is a *material* not elsewhere found, a morbific something as real as that from the poison oak, the leprous hand, the trichinous pork, or the syphilitic parent.

Efforts have been made to discover the form and other physical characteristics of miasmatic poison by the aid of the microscope and chemical reagents. Some investigators claim the ability to detect and define them in the atmosphere of various localities.

Contagion.—A healthy child entering a house where one is sick with scarlet fever, encountering nothing in the least offensive to the senses, in a few days has scarlatina.

Another, looking through a picture-book lately handled by a child recovering from measles, in due time presents a case of measles.

And another, riding for half an hour in a railway coach with a child that has mumps or whooping-cough, noticing nothing disagreeable, in a few days, perhaps a thousand miles away, is found to have mumps or whooping-cough.

A person never vaccinated nor inoculated with variolous matter, riding along a country road, on a frosty morning, a mile to the windward of a house in which is a case of small-pox, in two

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weeks thereafter, without further exposure, may have that dreaded disease.

In all these cases there is a *contagium*, a graft-germ, a material, passing from person to person, which no microscope has been able to define and no chemical tests to distinguish. Each seed has its own form and character, always reproducing its kind, without material variation. Hybridization may give rise to new species, and so extend the number of impalpable morbific organic agencies.

Gases.—Beside the transmissible seeds of disease, coming by inheritance, the invisible graft-germs and parasites, and the yet more impalpable miasms and contagions from various sources, there are gases in peculiar states and proportions, inorganic elements, immediately recognizable by no means or methods at our command, which operate as effective causes of disease.

Electricity.—And beyond these is the subtile agent known as electricity, appreciable only under peculiar circumstances, yet brought under human control and measurement. In dealing with it we are compelled to consider its *quantum* as well as *quo modo.* With all its tenuity its sick-making power is not questioned.

But we need look no farther in the field of impalpable morbific agencies.

Turning now to the data furnished by chemical tests and by spectroscopic and microscopic examinations of attenuated drugs, we find medicinal matter traced beyond the 6th decimal to the 8th, 9th, and some claim to the 12th.

One mathematician, upon the accepted theory of molecular magnitudes, tells us that one grain of the 11th centesimal attenuation may contain one atom of the drug-matter and not more; while another says the 15th centesimal dilution has one atom to each drop, and the 16th but one atom to every one hundred drops.

Taking the decimal scale the calculations of the former would warrant us in the conclusion that no medicinal matter exists in the 25th attenuation, or at least but one atom in every million of drops, while the calculations of the latter, considering the ultimate atom, or indivisible particle to be reached in the

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15th centesimal, would lead us to expect one atom of drug in each drop of the 30th decimal.

Beyond the 30th, so far as I am informed, no one claims either the practical or the theoretical presence of drug material.

As for drug-power existing beyond drug-presence I fail to find any proofs of such a condition in the field of morbific agencies. If the physiologist finds undoubted drug-effects from attenuations in which neither direct observation nor analogy can consent to there being drug-presence, we are only forced to the conclusion that the material drug may exist beyond the limits set by direct observation and analogy.

However we may theorize and philosophize about the persistence of force and its correlation, we cannot predicate potential drug-force where there is not some drug-matter. The force of a drug, its spirit, if you please, is no more recognizable and useful out of its own body than is the spirit of a man out of its body among men. If it were possible for it to be transferred by trituration or succussion to sugar of milk or alcohol, what would be the gain? Why labor so long to free the medicinal spirit from one body to have it "clothed upon" by another body? To those who recognize a dynamic medicinal spirit in the most inert substances, including sugar of milk, the question is pertinent: When the drug-spirit has taken possession of the sugar of milk, where is the dwelling-place of the disembodied spirit of the sugar of milk?

Let us consider these and other troublesome questions before we declare our unqualified adherence to the doctrine of medical spiritism. In avoiding the grossness of the old school let us not rush into the absurd transcendentalism of a small section of the new.

Tracing medicinal matter by one means and another, step by step, from the crude up to the finest, let us endeavor to so treat and so employ it as to escape the evil and obtain the good in the restoration of human health.

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PROOFS OF MEDICINAL POWER IN ATTENUATIONS ABOVE THE SIXTH DECIMAL.

By C. H. Lawton, M.D., Wilmington, Del.

I have the honor to present for your consideration a few thoughts with reference to the limits of drug attenuation, or proofs of medicinal power in attenuations above the 6th decimal. In doing so I shall not follow the beaten track, but shall call your attention to laws and principles that control all material substances, and shall endeavor to trace some analogy between them and the action of our homœopathic remedies.

Viewing the subject from this standpoint, I am aware, I go on dangerous ground; for this question has been the cause of more dissensions in our school, and has provoked more violent opposition, than all other questions combined.

Standing, as I do, in the presence of men who are veterans in the homœopathic ranks, men of culture and ability, and at whose feet I love to sit, it is natural I should feel some embarrassment in presenting a subject of such vital importance. With no wish to provoke a spirit of controversy, but with an earnest, honest desire, to search after the truth, I ask that you join me for a few moments in the investigation of this subject, the truth of which can only be approximated by the closest observation, and oft-repeated experiment. I say approximated, for we cannot understand it by experiment; it is still shrouded in mystery.

Gentlemen come here, year after year, and relate their experience, piling fact upon fact, showing the wonderful results achieved by the most minute doses; and year after year, others

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listen incredulous, and some are almost ready to give the lie, to what they cannot understand. Why is this?

One great cause, it seems to me, lies in the fact, that we are too much in the habit of using the terms high attenuations, high dilutions, and high potencies, indiscriminately. If, in making a statement, I use the terms arbitrarily, and not in harmony with the facts I wish to communicate, no logical mind can accept it. If I speak of increased medicinal power in connection with high attenuations and high dilutions, there is an incompatibility, a want of harmony in these terms, and its acceptance by others must depend upon its statement in terms that are in harmony with known laws—all truths must harmonize! Where then is the truth?

Again, gentlemen cannot accept facts based solely on experiment; they must either make the experiment themselves, or we must appeal to their judgment and reason; they must not only have facts, but these facts must harmonize with known laws. If in experimenting we develop facts *only*, our sphere of usefulness is limited; but if in developing facts, we unfold the underlying principles, while acting consistently with those principles, we can never make a mistake. It is a fact that the high potencies do act, although we cannot all accept it. Some of us know this by experience; others know it from the testimony of men standing in the foremost ranks of homœopathy, men of profound research and rare mental attainments, members of our own American Institute, and the peers of any who have lived since the days of Hahnemann.

We have the facts, either by experience, or from testimony; but science does not consist in an accumulation of facts merely, there must be a knowledge of principles whereby we may trace the *unknown*, from known phenomena, and may arrive at definite conclusions. Now, if we find that these facts harmonize with known laws, we have demonstrated a principle, and may draw conclusions which any logical mind can accept. In the further development of this subject I wish to submit the following propositions:

1st. The practical limit of drug attenuation is determined by the amount of resistance (inherent in the drug) opposed to the disorganizing or decomposing agent with which it is triturated;

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and this resistance depends on density and hardness. It is, therefore, impossible to establish any arbitrary rules for defining it.

2d. That beyond the limit of drug attenuation there is medicinal power.

Some minds are so organized that they can only accept as evidence that which is appreciable to the senses; if a thing looks strong, and smells strong, and tastes strong; if they can handle it, and it feels strong, they conclude that it is strong. We *know*, however, that the most powerful agents of which we have *any* knowledge, are those which we cannot see, nor smell, nor taste, nor handle. Electricity and magnetism are such. There is in every material substance (therefore in every drug substance) a force, which is the life of that substance, the organizing and controlling power, the active principle.

When any substance, solid or fluid, is decomposed, this latent force is set free, and becomes active or dynamic. This principle may be evolved either chemically or by friction, heat or magnetism. All substances continue in a state of rest unless acted upon by some external force. These are fundamental principles in science and philosophy, that no argument of mine can strengthen, and no amount of opposition can disprove. I will give a few illustrations.

Take any two substances, one of which is more easily oxidized than the other, bring them in contact with a third substance, which will act upon them chemically, and as the substance most easily acted upon is decomposed, there is a principle evolved which we can neither see, nor smell, nor taste, nor handle, but which, nevertheless, is the life principle, and was the organizing and controlling power of the substance acted upon.

This is beautifully illustrated by the galvanic battery, the life principle evolved by which is called chemical or galvanic electricity. This principle may also be developed by friction; the experiments with the glass rod, and with sealing wax, are so familiar, that it will be hardly necessary to do more than allude to them. In this case the principle developed is called frictional electricity. Heat will also develop this principle; take two bars of different kinds of metal, bring the ends into close contact, and heat them at their junction, and a like phenomenon will occur.

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Now, gentlemen, my thought is, that just as electricity dwells in all substances, and is made sensible only by friction, or decomposition, so in our potentized remedies the medicinal power is developed by friction or trituration. We know by experience that there is power developed by trituration. Is not this suggestion then, of likeness to electricity or magnetism, a suggestion in the right direction? This has been called life, without sense. I believe it is the life principle, and in the hands of Deity, the creative and creating power of the universe. Again, matter can neither give itself motion nor deprive itself of it. My hands have no power in themselves to move; my blood has no power in itself to circulate, my heart to throb, or my lungs to perform the function of respiration. They must be acted upon by some force external to themselves in order to perform the various kinds of motion to which they are adapted.

One more thought and I will close. It has been stated, and experience proves its truth, that, in the majority of cases, both acute and chronic, our potentized medicines act more promptly than the tinctures or low attenuations; I will go further, and think I may be justified in saying, that without potentization there is, and can be, no medicinal power. As material substances have no power in themselves to act, and as there can be no force without decomposition; I submit, that, if we give our medicines in the crude state, or in the low attenuations, this process of decomposition must be performed in the stomach before the medicinal power can be developed. Hence the retarded action of low attenuations.

In conclusion, I submit the following:

1st. That attenuation is simply the commingling, or the uniting in one mass, of a medicinal with a non-medicinal substance.

2d. To potentize, or in other words, to develop medicinal powers there must be decomposition.

3d. The amount of medicinal power is in proportion to the complete or partial decomposition of the drug acted upon.

4th. A point, when decomposition is complete and the medicinal power fully developed, marks the limit of drug attenuation.

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THE PROOFS OF MEDICINAL PRESENCE AND EFFICACY IN ATTENUATIONS ABOVE THE SIXTH DECIMAL,

AS FURNISHED BY CLINICAL EXPERIENCE IN THE USE OF ATTENUATIONS RANGING FROM THE FIFTEENTH TO THE THIRTIETH DECIMAL.

By A. C. Cowperthwaite, M.D., Iowa City, Iowa.

Many centuries ago it was decreed that man should not live by bread alone, or, in other words, that life was not altogether made up of those things which constitute the material, but that it must draw much of its pabulum from the fountains of the unknown. So, in all the elements which go to make up life, from its humblest to its most exalted manifestations, from the child in the cradle to the gray-haired scientist, do we find all the relations of life involving both the known and the unknown quantities. Were it not so, advancement, both moral and intellectual, would cease, for without the incentive of the unknown continually before us, the desire to unravel its mysteries would not exist, inductive reasoning would become unnecessary, and man, contented with himself and his surroundings, would cease to be the active, inspiring element of progress which he now is, and would become a mere listless automaton, performing mechanically the necessary duties of life.

Such, comparatively, is the man of the present day who attempts to deal only with known quantities, who believes only that which the sense of touch or sight may reveal to him. That physician who refuses to traverse that borderland in which dwells the unknowable of the scientist is in serious danger of shipwreck

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on the shoals of inactivity. For that which is unknowable to-day may not be unknowable to-morrow, and the drug potency yielding no medicinal molecules to-day may, in the hands of the future scientist, become rich in the finely divided elements of the original substance.

Hahnemann (when he discovered that under the guidance of the law of cure the sensitive human organism would not tolerate as large doses as he had previously employed) sought to establish some plan by which the size of the dose might be systematically reduced. Of the success of his efforts we are well aware. When the aggravation of symptoms still attended the administration of the lower preparations, and he felt the necessity of still further reducing the size of the dose, Hahnemann, although appreciating his far departure from the original substance, did not point the microscope to each successive potency in order to assure himself of actual drug presence. This he considered an unnecessary test, for equally conclusive to him was the action of the medicine upon the diseased organism. When, as he ascended the scale of potencies, he saw precisely the same effects attending the administration of his remedy, save the absence of the medicinal aggravation, he wisely concluded that such action could only result from the drug administered, else why could these results be foretold with such precision? The patient tossing about with a burning fever on receiving Acon.[30] would break out in a profuse perspiration and the fever would abate. And this, occurring time and time again, was conclusive evidence to Hahnemann that Aconite did it. Should it not be conclusive evidence to others as well? And when Hahnemann's experience has been repeated many thousand times by his followers, not only with Aconite as mentioned, but also with many other remedies, should not the medicinal efficacy existing in the 30th potencies be clearly acknowledged, and the subject no longer remain an open question? It is a fact acknowledged by all homœopathists that the curative action of a drug, when properly selected, is not in direct ratio with the quantity of the drug employed. This principle was set forth when Hahnemann passed from crude materials, by the scruple and drachm, to drops and grains of tinctures and triturations, just as much as when urged by additional experi-

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ence he passed from the latter to pellets of the 30th potency. The physician who prescribes only low potencies admits the truth of this statement equally with him who relies upon the higher potencies. So, we may safely assume it to be an accepted doctrine of the homœopathic school that, "the curative power of drugs is not in the proportion of their material quantity." This fact once acknowledged, where shall the line be drawn, and who shall say at what point in drug potentizations medicinal efficacy is lost? Again, it is a conceded point that trituration and dilution develop curative power in substances which in their crude state are inert, viz., silica, salt, tin, gold, etc. If this be the case, and it most certainly is, who is to say what point marks the limit of this development? Experience alone can establish these points, and it has already demonstrated beyond cavil that, to say the least, development of curative power does not cease below the 30th potency. I say experience has demonstrated this fact. If not, then experience is of no value, and the accumulated wisdom of Hahnemann, of Bonninghausen, of Dunham, and others only fills a blank page in our literature.

Statistics go far toward proving the medicinal efficacy of the 30th potencies, but I will detain you only by referring to the well-known experiments of Drs. Wurmb and Kasper, in the Leopoldstadt Hospital at Vienna. These gentlemen had no confidence whatever in high potencies, but determined to establish a series of experiments in order to arrive at a solution of the question of dose. So during the ten years from 1850 to 1859, inclusive, all cases in this hospital were treated for the first three years with the 30th decimal dilution, for the second three years with the 6th, and for the remaining four years with the 15th. At the end of the ten years Dr. Eidherr undertook the task of collating the material thus obtained, and confined his investigations to a single disease, pneumonia, for the reason that the diagnosis of this disease is easy, and that, by means of the physical signs, its course, progress, and decline could be more accurately followed and observed than is the case with many other acute diseases. His investigations were conducted with the greatest care, and all outside influences taken into consideration, even to the different atmospheric conditions

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of each period. As regards the latter, it was determined that "during the first epoch the atmospheric conditions were most favorable to the prevalence and severity of pneumonia, and therefore the *least* favorable for the treatment; during the *second* epoch *least* favorable to the spread and severity of pneumonia, and therefore the *most* favorable for the treatment."

The cases occurring during the first period were designated by Dr. Eidherr as Group 1, those during the second period as Group 2, and those of the third period as Group 3.

The physical signs of each stage of the disease were very carefully noted, and the comparison between the groups made with reference to all these points. The following is the result:

The average duration of the infiltration was:

For Group 1, ...	3.0 days.
" " 2, ...	4.1 "
" " 3, ...	3.0 "

Resolution began:

For Group 1, ...	on the 3d day.
" " 2, ...	" 3 5 "
" " 3, ...	" 3.2 "

Resolution was complete:

For Group 1, ...	on the 4 9 day.
" " 2, ...	" 6.9 "
" " 3, ...	" 6.3 "

The physical signs of the infiltration vanished:

For Group 1, ...	on the 7 1 day.
" " 2, ...	" 9.3 "
" " 3, ...	" 10 3 "

The physical signs of the exudation vanished:

For Group 1, ...	on the 12.3 day.
" " 2, ...	" 20 5 "
" " 3, ...	" 18.1 "

The average duration of each case from its reception to its dismissal:

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For Group 1, ...	11.3 days.
" " 2, ...	19.5 "
" " 3, ...	14.6 "

From these valuable figures we not only learn positively that there is medicinal power in the 30th potency, but we may safely conclude, in fact must conclude, that 30th potencies, at least in pneumonia, are to be preferred to the lower potencies.

In addition to these statistics we should not fail to take account of the success of those individual practitioners who have relied mostly upon the 30th, or still higher potencies—Hahnemann, Bonninghausen, and others, in both Europe and America. These gentlemen have won world-wide reputations as successful practitioners, and, to say the least, their successes in practice will very favorably compare with those of our friends who rely exclusively upon the low preparations. Nor should we forget a fact in the history of homœopathy, recently brought to notice by Dr. Lippe, who writes as follows: "Homœopathy was introduced into the United States about fifty years ago. The early pioneers, as we well remember, had only the 30th potency at their command. The only shop in the United States where homœopathic medicines were for sale was in Broad street, Philadelphia, kept by J. G. Wesselhœft, and this bookseller imported them from Europe. With these 30th potencies as their only outfit in the way of medicine, but with a full knowledge of Hahnemann's teachings, and strictly following the rules laid down in the *Organon* in the application of the principles governing the homœopathic healing art, did these early pioneers enter upon their mission 'to cure the sick.' Our skeptics of the present day, then, should remember that the foundation upon which homœopathy has been so rapidly and so successfully builded in America, was laid by the successful use of the 30th potencies. Had the experiment, though such it was not considered, failed at that time, had it been proven that the 30th potencies contained no curative power, homœopathy would to-day have been a thing of the past. Had it not been for the triumphant successes which attended the use of these potencies in the hands of those pioneers, the young members of our profession to-day, instead of attempting to unsettle facts most thoroughly established fifty years ago,

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would have been entirely ignorant, save from history, that such a school of medicine ever existed. How ungrateful, then, and foolish, to assail their own birthright, and to attempt to tear down the foundation upon which they themselves are builded, and to which they owe their professional existence."

But the materialists of the present day would have us understand that clinical proofs are of no validity, and very wisely turn to the patent medicine almanac as proof of their position. To admit such a comparison should hardly be allowed. The homœopathic remedy prescribed upon a scientific basis is expected, according to the law of similars, to effect certain definite results, which may be presaged with remarkable certainty. On the other hand, the so-called clinical proofs of the patent medicine action are only the indefinite and unwarrantable conclusions of unprofessional minds, enlarged and embellished by the proprietor of the nostrum for pecuniary benefit. There is no similarity whatever between the two.

That clinical proofs, when not surrounded by proper restrictions, and when not conducted by observers of integrity and scientific capacity, may become worthless we admit, but it is not of such that we would speak, nor is it necessary to take such into account when we have before us the authentic and reliable case-books of Hahnemann, Bonninghausen, Dunham, and many others. So when we have clinical proofs which are the result of the single homœopathic remedy prescribed in precise accordance with the homœopathic law of cure, and untrammelled by any deleterious or antidotal influences, and in cases where the diagnosis is established beyond question, may we safely say that such proofs are of equal importance and rank with those proofs which, to the chemist, decides the proportions of a compound, or, to the physiologist, establishes the relations of the life processes, or which tells the astronomer in advance the movement of the heavenly bodies. Each is the definite result of an applied natural law, and in this sense each is of equal importance to the other.

Not only is there therapeutic power in the 30th potency, but pathogenetic power as well. Hundreds of authentic provings with the 30th potencies are recorded, in which the positive and

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distinct pathogenesis of the drug, as afforded by poisonings and by provings with the crude material, are verified. If then the 30th potencies have been proved to possess pathogenetic power, their therapeutic virtues must be acknowledged. Nor can we overcome the facts of these authentic provings by sneering at motives, or by calling into question the veracity or reliability of the prover. Take, if you please, the provings of Rhus rad.[30] made by Dr. Joslin. Note the rheumatic character of the pains produced, even to the retaining of the Rhus peculiarity, worse when first beginning to move. Also observe the skin symptoms giving the peculiar eruption with much burning and smarting, so that Dr. Joslin himself remarks that, "the effects apparently produced by the 30th, agreed in character and location very closely with those caused in many by the contact of the legs and feet with the leaves of the living vine." Can it be said that such symptoms were the result of imagination? Not at all. This, 'tis true, only argues as to the pathogenetic power, but we need not go far to establish the curative. My own experience, aside from that of scores of others present, guarantees the fact that this class of symptoms have very many times been removed by Rhus[30], nor is it necessary to prove a fact so positively well known. Yet in this connection pardon a single case: Dr. Hupfield reports the case of a colored woman aged 33, who had had rheumatism for five years, suffering every day, and at times very severe attacks. The chief characteristic being "excessive pain and stiffness of the limbs," the latter especially on rising after being seated. Four doses of Rhus tox.[30] produced a radical cure. A few special cases, and I will close:

Dr. Fanning reports the following: A woman, aged 28, after an attack of typhoid fever under old-school treatment, had a chronic diarrhœa alternating with constipation lasting over a year; the chief peculiarity of the diarrhœic attacks was a sensation of something pulling at the umbilicus, with actual retraction at the navel. A few doses of Plumb. met.[30] gave an immediate cure.

Dr. Brown, of Binghamton, reports the case of a lady having paroxysms of excruciating pain at the stomach, as if "sticking the parts with a knife," which had lasted under allopathic

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and homœopathic treatment over a year. One dose of Phos.[30] cured immediately.

Dr. Betts reports a case of constipation, with no desire for stool or ability to pass stool, cured with one dose of Alumina[30].

Dr. Boparius reports a case of flatulence of several years' standing cured with Phos.[30]

My colleague on this bureau, Dr. Lawton, of Wilmington, Del., furnishes the following remarkable case: A lady, subject to periodical attacks of renal colic, which had always yielded promptly to Lyc.[30] (Tafel), sent for medicine saying, "You know just what I want, doctor; it is one of my old attacks." I sent her one powder of Lyc.[30] to be dissolved and taken in water, a teaspoonful every half hour until relieved. I also sent a second powder (Sac. lac.) to be dissolved and taken after the first had been discontinued. In about three hours I was sent for to come immediately, the patient being a great deal worse. Found her symptoms all aggravated, while she was tossing from one side of the bed to the other in great agony.

I asked if she had been better at any time since taking the medicine, and was told that after taking *two* doses she was relieved and thought she could sleep. In the meantime her medicine became again due, and she took another dose. From that time she became uneasy, and continued to grow worse every time the medicine was repeated. I decided that she was getting aggravations from Lyc., and stepping to the bed gave a few pellets of Camph.[30] dry on the tongue. In less than a minute she was relieved and had no return of the pain.

From my own case-book a few cases:

Three cases of facial paralysis,—two of long standing, and one recent,—each cured within ten days, the recent case in three days, with Caust.[30]

In a low case of typhoid fever, fifteenth day. Patient unconscious, trembling of lower lip, constant for five days. One dose Arnica[30]; in half an hour the trembling ceased and did not return, and on further use of the same remedy consciousness soon returned and the patient made a rapid recovery.

I had always been afraid to rely upon the higher potencies in the treatment of croup, until upon one occasion I found my-

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self several miles in the country with my Aconite vial empty. The 30th was all I had, so I prescribed it, and instead of waiting half an hour or longer, as I had previously done, for the much-desired perspiration and accompanying relief, I only had to wait five minutes, and I saw the most rapid and beautiful results I had ever witnessed. To this day Acon.[30] in such cases has never failed me.

In my college clinic, a case of constipation in a scrofulous young man of 22, a cripple from white swelling, who had not had a natural evacuation since five years of age, either using injections or cathartics, was cured in three months with Bry.[30] on the indication, "stool hard and dry, as if burnt."

Also a case of intermittent of six months' duration under old-school treatment. Shaking every day or every second day, at irregular intervals; chills and heat mixed; pale, yellow, cachectic look. Prescribed Ars.[30]. Not another chill occurred, and the patient recovered at once.

But these are only a few cases out of thousands that might be offered in connection with other arguments we have adduced to show the "medicinal presence and efficacy in the 30th potency as furnished by clinical experience." Why need we go farther? These are incontrovertible facts, and, surely, if they do not convince, you "would not be persuaded though one rose from the dead."

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PROOFS OF MEDICINAL PRESENCE AND EFFICACY IN ATTENUATIONS ABOVE THE THIRTIETH DECIMAL,

AS FURNISHED BY THE TESTS OF CLINICAL EXPERIENCE.

By C. H. Lawton, M.D., Wilmington, Del.

The strongest evidence and the most convincing proof of medicinal presence and curative power in our high potencies is that they cure. Having been assigned by our chairman the work of collecting proofs from clinical experience of medicinal power in the use of attenuations above the 30th decimal, and believing that the testimony of a number of physicians from different parts of the country would be more convincing and conclusive than the limited experience of any one man, I have solicited and obtained the following reports from gentlemen who are well known to the most of you as close observers, successful practitioners, *able exponents* of the homœopathic law, and worthy the confidence and support of every member of this Institute.

These reports, so far as time will permit, I now have the honor to read.

Mr. S. K., age 44, married, by occupation a merchant. Active habits; bathes twice a week; five feet ten inches in height; gaining in flesh; complexion sallow. Has been ill a year and a half. Father was subject to rheumatism of legs, rhus-type. Former treatment allopathic. Has considered himself incurable, and has had no treatment for several months. His temperament is nervo-bilious-sanguine, is very nervous and irritable; pulse very weak, and 66 to the minute. If startled or frightened has palpitation

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of the heart; sounds of the heart normal. Circulation in hands and feet good, except in the winter. Tongue slightly coated; teeth sound; appetite good; sometimes whilst eating, nausea, and sometimes vomits ingesta. Stools undigested; bowels constipated. Rheumatic pains in right shoulder, caused by draft of air, followed by an attack one year ago. Has stiffness of thighs without pain, better from constant motion. Feels weak, and is unable to bear fatigue. Intense itching of the skin, with formication all over the body, without any eruption; has no periodicity, except it is *worse while undressing*. On this date, October 31st, 1874, I gave him one dose on the tongue of Oleander^{200}, and followed with a dose, every three hours, of the same.

November 4th, 1874. Pulse 76. Tongue not changed in appearance. Undigested stools, perhaps a little better. Other symptoms no change. Continued same treatment. After this prescription, he rapidly improved, and took no more medicine. I frequently meet him on the street, and he has remained well up to this date, March 1st, 1880.

The symptoms which I deemed characteristic of Oleander were the intense itching, *worse while undressing*, which I have frequently corroborated, and the undigested stools.

P. S.—I ought to say that the potency was the 200th centesimal, made by Tafel, and by hand.

H. Noah Martin, M.D.,
Philadelphia, Pa.

Mr. Geo. A. M., aged about 30 years, wholesale grocer, active habits; lost his mother a year ago, and an infant child six months ago; exerted himself much in nursing. Complains of shortness of breath, bruised soreness, and stitching pains in region of left ventricle of the heart.

Percussion, shows cardiac dulness, extended to the left nipple-line and somewhat beyond. Palpation: excessive action of heart; impulse of apex, very strong to nipple-line, and upward to above nipple. Auscultation, inconstant blowing sounds at apex, and from aortic orifice to great vessels, momentary in duration; no continuous valvular murmurs. Face pale and anxious; eyes appear somewhat fixed.

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March 26th, 1880. I prescribed Arnica^{200}, night and morning (No. 40 pellets, three at a dose).

March 30th. Feels much better in every way. The heart is more quiet and less sore. ℞. Sac. lac.

April 5th. Still better; cardiac dulness less extensive; impulse less extended upward, and to left. ℞. Sac. lac.

April 11th. Better. ℞. Sac. lac.

April 22d. Better as to heart, but has been moving; exerted himself going up and down stairs, and was exposed to cold. Now has pleuritic stitches in the right side of chest, worse by inspiration and motion. ℞. Bryonia^{200}, three times a day, three days, followed by Sac. lac.

May 1st. Complains of nothing; feels quite well. Physical examination shows the cardiac dulness and apex impulse normal; sounds normal. Discharged.

J. C. MORGAN, M.D.,
Philadelphia, Pa.

No. 1. A boy, aged 7 years. Convulsions; starts from sleep, with red face, frightened looks, staring eyes, and convulsive jerkings of the body. *Bellad.* 6^{m} (made by hand on the Hahnemannian plan), relieved. A relapse the next day yielded to a dose of similarly prepared 10^{m}. Had had convulsions before, but has had none since (one year).

No. 2. Miss ——, under treatment for ten months. Some symptoms yielded, but the following resisted the usual remedies. Ineffectual urging to urinate; when it does pass it comes in drops with much straining and intense pain; worse before menses. Headache the third day of the menses, the flow suddenly stops, then the headache ensues. Dim vision; worse when stomach is out of order.

Lith. carb. 10^{m} Fincke relieved promptly.

E. A. FARRINGTON, M.D.,
Philadelphia, Pa.

June, 1879. Etta S., aged 14 months, bright, healthy appearance. Chill in the morning, two hours earlier every other day. Awakens bright, becomes thirsty, after a little time falls asleep, has a marked chill, blue nails, fingers and tips, followed by high

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fever, flushed face, somewhat restless, then profuse and general sweat, after which she awakens in good spirits. Opium[200], Nux vom.[1000], Bry.[200], etc., failed. Nux mos.[200], a powder every six hours. No more chills to date. While sleepiness is a characteristic of Nux mos. I find no mention of the *profound sleep during all the stages* of an intermittent fever, which was the characteristic symptom of this case.

I cured a case of three years' standing in the same family with Cimex[200]. Characteristic symptoms, drawing under the knees, and sensation, during the chill, "as if the body were contracted."

J. B. GREGG CUSTIS, M.D.,
Washington, D. C.

A gentleman, aged 35, called on me to prescribe for a facial neuralgia. The indications being for Arsenic, I prescribed one dose Arsenic 200 Fincke. He clapped his hands to his head in intense agony, and cried: "Doctor, why did you give me Arsenic? I ought to have told you that I never can take Arsenic." He remained in intense agony for about five minutes, when the pain disappeared, and his neuralgia never recurred. He had no means whatever of knowing what medicine it was that I had prescribed.

A. C. COWPERTHWAITE, M.D., PH.D.,
Iowa City, Iowa.

An old man, seventy-five years old, but otherwise hale and hearty, a good eater, complained for about one month of dizziness, with tendency to fall on left side; he fell once or twice when walking in the street, but never lost consciousness or, if so, only for a second or two. All secretions and excretions normal; radial pulse, 60, hard and tense, perhaps from atheromatous condition of arteries.

Vertigo with inclination to fall to left side is found in Aur., Cil., Dros., Euphorb., Lach., Mercur., Mez., Sulph. zinc.

Remedies for aged people, Ambra, Baryta, Con., Opii, Sec.

The indications for Aurum met. were clear, and in the 200th potency, a dose morning and evening, for a few days, relieved

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the vertigo entirely; the removal of the atheromatous condition was out of the question.

SAMUEL LILIENTHAL, M.D.,
New York, N. Y.

AGGRAVATION FROM RUTA GRAVEOLENS 200th.

On February 2d, 1872, I was consulted by Mr. B——, about fifty-five years old. He has for years been subject to prolapsus of the rectum. During stool, and even when *lifting* hard, the bowels would protrude to the extent of an inch or more. He was in the habit of evacuating the bowels soon before retiring, as it was difficult to retain the bowel for some hours after stool, unless he kept in a recumbent position. After a careful comparison of all his symptoms with those of *Ruta graveolens*, I gave that medicine in the following manner: Twelve powders of *Sac. lactis*, numbered. In Nos. 1, 4, 8, and 12 were a few pellets of *Ruta* 200th, the others were blank, but also contained blank pellets, that they might all appear alike. (This is my usual custom when giving blanks and medicated powders.) A powder to be taken at 10 A.M. every day. After the powders were all taken, he reported that on the days he had taken Nos. 1, 4, 8, and 12, he had several diarrhœic stools, followed by such general prostration and weakness of the bowel (as he expressed it), that he was obliged to keep in the house, and very quiet for twenty-four hours, as even slight exertion would cause a descent of the bowel.

Left him without medicine for a few days, and wrote to Dr. William Eggert, for advice, and requested him to send me *Ruta* very high. Dr. Eggert advised me to wait on the action of the 200th, as an aggravation was generally a pretty certain indication that the correct remedy had been given. He had no higher potency of *Ruta* to send me. On the 24th of same month, twelve days after the last dose of *Ruta*, no improvement having taken place and not being fully satisfied that the medicine had caused the aggravation, I gave him a similar package of powders, only numbering the medicated ones 3 and 9. Again he reports that Nos. 3 and 9 were the same remedy that I gave him before in Nos. 1, 4, 8, and 12, causing exactly the same train of symp-

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toms, and begging me to give him no more of that kind, as it made him sick.

From this time on to April 5th following, I kept him on blanks, numbered as before, but no improvement following, I gave him another dose of *Ruta* 200th, with precisely the same result, and he discontinued treatment.

In this case there was no possible chance for the patient to ascertain beforehand any difference between the powders, as all appeared and tasted alike, and he did not see them put up.

The *Ruta* was Tafel's 200th, the only preparation of the remedy I then possessed.

A. L. FISHER, M.D.,
Elkhart, Ind.

TYPHLITIS.

Patient, stout healthy boy, aged twelve years, dark hair and eyes; on November 1st, 1879, swallowed a leaden bullet, larger than a No. 80 globule, and weighing 75 grains, or nearly 4 scruples.

For a week afterwards suffered no inconvenience except constipation; bowels moving but once during that time. Was called to treat him November 8th for pain and tenderness in the bowels, worse in right iliac region, loss of appetite, white furred tongue, slight nausea, feverishness, pulse 90, temperature 100, thirst, but not for large quantities of water. The pain was not spasmodic like colic, but a constant sore pain, aggravated by motion. Patient could not tell if the bullet had passed. Bowels had moved but once since it had been swallowed, and not at all for three days.

Was this a case of lead poisoning? or had the foreign substance anything to do with what appeared to be enteritis?

Nothing else could be assigned as a cause; no cold, or imprudence in eating or drinking. Gave Plumb. met. 50^m, in water, a dessertspoonful every two hours, till three were taken, then if better to be discontinued. Next day patient easier; medicine had been given irregularly during the night, as the sleep was disturbed. Pulse still 90, temperature much the same. Medicine continued, three powders, three hours apart. In twenty-four

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hours the case was still further improved; pulse and temperature lower; soreness not so great, and more circumscribed. Three more powders of Plumb. were given, three hours between. Did not hear from patient again for two days, when a message came that he was much worse. Found him lying on right side, with right limb drawn up; could not be moved without great pain. Complained of a hard, sore lump, the size of a man's fist, in the right iliac fossa. Pulse 100; temperature 100; disgust for food; tongue white; nausea; urine very slight, and dark brown; constipation, no action of bowels for seven days. Gave Lyc.^{cm} in solution, dessertspoonful every two hours, unless better. Next day, much worse; had had a bad night, no sleep, pulse 110, temperature 101; constant moaning and screaming with pain in the lump, which was now as large as a man's two fists, hard and very tender, with slight discoloration of the surface. Everything taken into the stomach was now rejected; vomiting had continued for twenty hours. Besides the slight nourishment taken there was a green ropy fluid thrown up. Still no action of the bowels. Tepid water injectments had been given, but passed off without effect. No urine passed for twenty-four hours. Friends were anxious. Allopathic physicians, who heard of the case, predicted death certain, and not far distant. An abscess evidently seemed about to form in the region of the obstruction; and how was this to be averted? The bowels must move, or the patient will die, say the allopaths, and the allopathically inclined; but how is this to be brought about? By the hazardous operation of a cathartic? a failure of which to effect this end would only add to the pressure and inflammation, and thereby insure certain death.

Is this a case where the law of the similars is suspended or inapplicable, and the physician justified in resorting to anything known to the medical world to save the life of the patient, an only child, and criminally culpable if he did not? Can we conceive of a more complicated or dangerous condition, or one that it would seem was more beyond the sphere of medication? But even in this dreadful state of affairs, homœopathy, pure, rigid, and *unadulterated*, is the only auxiliary required. Hepar sulph., 1000th (Tafel), in solution, was given, a dessertspoon-

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ful every two hours for twenty hours, without intermission, by which time the vomiting had ceased, the pulse fallen to 105, temperature 100, urine passed freely, pain and expression better, lump softer and not so tender, medicine continued at longer intervals. Next day, the ninth of the treatment, very much improved; pulse 100, temperature 100, had slept three hours during the night, taken and retained nourishment; medicine continued every four hours. In twenty-four more pulse 95, temperature normal, pain and soreness greatly relieved, bowels had moved freely, filling a gallon chamber one-third full, in which there were eight or ten hard dark balls over an inch in diameter, and covered with slime; the balance varied in color and consistency, a part being brown and thin, and all very offensive. Unfortunately this stool was destroyed without being carefully examined for the bullet, which very probably had also passed off.

This was the tenth day of the treatment, and the thirteenth day from the time the bowels had last moved. The tumefaction and soreness now gradually subsided, and a permanent recovery followed.

The only reason for giving the medicine in the 1000th potency was that I did not have it any higher.

C. PEARSON, M.D.,
Washington, D. C.

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APPENDIX.

DISCUSSION.

S. LILIENTHAL, M.D., New York: To set the ball in motion, as it seems to be at a standstill, and nobody wants to get up, I will say a few words. The first thing I want to say is that since Professor T. F. Allen, after sending in his report, wanted to make his own provings, he wanted to select his own medicine. It was understood that Dr. Sherman was to make them. After he was informed of this he withdrew. I must say that I have felt perfectly happy the whole day at the report which was made by the Bureau of Materia Medica. We have found out that chemistry fails entirely in proving the value of high dilutions. It was acknowledged that the spectroscope fails. We have found out also that the microscope fails to answer the question as to high potency. I thank my friend Dr. Sherman for his labor. I can only see from his report that there is a difference between the well body and the sick body, and that we often find a reagent in sickness to which our high dilutions are especially attractive. For instance, you might have a proving on the healthy body and find that they are acting perfectly well. On a sick person it would be different. I believe this is the fact without doubt. Professor Dake, in his first part, acknowledged that neither chemistry, nor the microscope, nor the spectroscope has ever found a difference in the blood, whether it be a miasm or anything else. There is then a higher power or force, an elevating force behind those germs, or a life force, if you please. Nobody has ever seen it. We know it only by its effects on the body. We cannot hold it, we cannot take it in our hand. That was acknowledged by Professor Dake. He acknowledged that the spirit is not recognizable. The papers of Professor Cowperthwaite and of Dr. Lawton, were most satisfactory. One of the most beautiful expressions which I heard was given by Dr. Lawton. He said: "There is the soul of the drug acting, we are all aware, in the living person." Now nobody knows where

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that soul is, yet they know it is in us. It works in us. It is constantly at work. Just such a soul, if I may use the expression, is in the drug. It works; but you have to liberate it, and by being liberated it works quickly, immediately, and we see the benefit of it.

Now comes the question, why do not others see it? Macht's nach, macht aber genau nach. Try it, but do not say it don't work. You may say you do not understand it, that will be a free confession. You may say you do not know how it works, that may be the truth. You may say I do not understand a great deal of physiology, I only know the effects. Just so you see the results.

I only beg of you, those who have a prejudice against high dilutions, to be sure you are right. That is, be sure you are right in the selection of a remedy. Be sure you are right in your diagnosis of the disease, and that is the *totality of the symptoms*, and nothing else. All the pathology, live pathology, I do not mean pathological anatomy, but living pathology, is nothing less than what Hahnemann so beautifully called it, the totality of the symptoms. You get the totality of the symptoms and you cover them carefully, you cover them with the right remedy and you will always cure your case. If your case is not cured, you may be sure that you are at fault. The trouble is not in the dilution but in your judgment.

Dr. Adolph Lippe, Philadelphia, Pa.: Mr. President, permit me to make a few remarks on the paper read by Dr. Sherman. He seems to be in error when he reflects upon people whom he calls believers in high potencies, who have not taken any part in these proposed provings, because, impliedly, he meant to say that they were afraid that their belief would come to grief. Those that have used medicines according to the rules laid down by Samuel Hahnemann, are not believers. They are convinced of the effect of the smallest dose. It is not a belief, it is a conviction—conviction obtained by experiment. It is for that reason, and that is one of the reasons, why they have taken no notice whatsoever of that proposed reproving of the 30th potency. But if Dr. Sherman had been good enough to read his homœopathic literature, he would have found that that experiment had been made in Vienna thirty odd years ago by Dr. Watcher, on Natrum muriaticum. He found that Natrum muriaticum cured the disease in the high potencies. What was the result of all that proving? Dr. Watcher was anxious to prove the 30th potency. He did not believe in it. The experiment was made, first on the healthy and then on the sick. He was honest enough to say, that he was grieved to be compelled

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to acknowledge that the 30th potency was of great efficacy in producing conditions on the healthy organism, and in curing sick people in a very short time. More so than the lower potency. We can say that at that time it was settled.

Now here we are, thirty years later, called upon to prove that over again. Now, if Dr. Sherman was very anxious to do so, he might have followed the plan of Dr. Watcher—made his first provings of the potency upon the healthy, obtained all the symptoms thereby, and obtained a cure. But Dr. Watcher not only produced with the 30th potency many symptoms, but forty times more symptoms than he had produced with the lower potency. He corroborated Hahnemann's Natrum muriaticum symptoms, and added materially to the knowledge of the inert drug substance. That is the way to make provings. It is the plan proposed, but it has not been responded to, for the very reasons that I have now stated; not because there was any particular objection to it, except the objection that it was useless, and our time can be better employed by developing homœopathy than by proving and reproving again that which was known thirty years ago to be true.

Alvin E. Small, M.D., Chicago, Ill.: I was not present, unfortunately, when the reports were read on Materia Medica, but it struck me as being rather queer, when I read the title of the papers given here, as furnishing, for instance, a test for chemistry. Now, if we want a physiological proving, what has chemistry to do with it? We do not want to prove our remedies by chemistry, we want to prove our remedies on the living subject. We trace them to vital conditions, and be sure we regard the law. We want to be sure how far the system is impressible to the action of remedies. We cannot test or measure a remedy by chemistry, neither can we by the microscope or the spectroscope; we cannot prove them by these instruments. It is only on the living subject that we can prove them. We know that these living subjects are susceptible to a variety of changes which exist in nature, which chemistry can never touch, and of which no measurement by any instrument which you can invent can be made.

I will ask you what makes the oak grow? You can plant an acorn in sand or shot and water it with rain-water, and it will extract nutriment from the rain-water. The nutriment is as infinitesimal as the highest potency you can name. The tree will be elaborated, and when sufficient rain-water has been furnished this acorn will germinate, it will grow, and produce a tree, and it will spread its branches, and if you will take the pains to analyze that tree you will find many chemical elements in the tree

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which you cannot find in the rain-water. There is a singular metamorphosis which takes place in living beings. Now we have read of the lichen which feeds on the atmosphere, and yet it sends out roots, and will elaborate itself and become a vegetable and a plant that can be seen by the naked eye. Now where did it come from? where does this impress come from that is made upon the living tissues? When the plant has developed itself it yields, on analysis, the same chemical elements that you will find in other bodies of nature. Nature is full of these forces, and a remedy addressed to the vital forces will produce a modification of the system, so that no estimate can be obtained by measurement. We have seen this. I would like to relate a fact which I saw myself, in Philadelphia.

I was called to see a lady there, who said to me: "Doctor, don't you dare to give me any Pulsatilla; it always distresses me so that I do not wish you to give it to me." Some time after this I was in attendance upon her, in a fit of sickness. Her symptoms seemed to justify the prescription of Pulsatilla. I recollected what she had said, and I selected a very high potency —Jenichen's potency—such as I thought she never would detect, even if I administered it to her. I gave it to her and said nothing, and I mentioned it to no person whatever. The next time she saw me she said:

"I told you never to give me any Pulsatilla; I never have the feelings that I experience except when I take Pulsatilla."

Now that was the 800th potency. I have seen other cases where the impressibility of the system was so great that the most infinitesimal dose can produce an effect upon the vital forces.

I once was attending a patient who was singularly affected by the odor of musk; she could never endure the odor of musk without its superinducing a fit of syncope. Now all philosophers agree that odors are small particles escaping from odoriferous bodies. You may think it strange that the odor of musk would produce this syncope upon a patient, but it is a fact. You may call it idiosyncrasy, or call it an impressible condition of the system, but it is a fact nevertheless. The patient becomes affected with the musk, and experiences a fit of sickness. How many patients have we seen affected by the odor of a rose or some other flower? We know that this odor produces an action upon the living economy, and there is no kind of measurement that can be inflicted upon the dose that has been administered.

F. R. McManus, M.D., Baltimore, Md.: My friend, Dr. Small, has been speaking about the impressibility of the human system. I knew a lady who lived in Baltimore, 35 years of age, and there was nothing that seemed to disturb her equanimity.

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She was in ordinary health, but the odor of a shrub affected her seriously. Experiments were tried by her astute allopathic physician, to ascertain if he could not bring a shrub into the room without being detected by her, but it always produced syncope; she could not pretend to handle it at all, or to smell it. For fear he would be mistaken about it, Dr. John Taylor, who was the physician of Baltimore in the olden times, spoke to me of the case; he was her physician. He took a shrub and an ordinary-sized pocket handkerchief, and he put it in one corner and folded it, and wrapped it, and wrapped it, and wrapped it, and folded it together, and then he wrapped around it a silk pocket handkerchief, and he put it in his pocket. He was attending her professionally; he visited her. She said to him:

"Doctor, I feel very weak."

"Well," says he, "what is the matter; are you in pain?"

"No, I have no pain, but I feel weak; I feel a weakness coming over me."

"What kind of a weakness; what do you suppose produces it? I am only feeling your pulse."

"Well," she says, "I have a feeling such as I always have from the odor of shrub."

Now that is the history of one case that I heard of in my life, but it is a fact. It only proves the impressibility of the system.

THE PRESIDENT: Several gentlemen wish to know the name of the plant. What was the name of the plant?

F. R. MCMANUS, M.D., Baltimore, Md.: The common garden shrub, calycanthus. That was an extraordinary case; I mentioned it as corroborating what Dr. Small says.

WILLIAM OWENS, M.D., Cincinnati, O.: In regard to the report which has been presented by the Bureau of Materia Medica, I must say for myself that I have been actually disappointed. I had expected to hear a reference to some drugs in the report, and their application on the human organization, as we understand it, in their relations to homœopathy. I expected to hear a report upon drugs, and their relation to the human organization, which is the proper function of the Bureau of Materia Medica, Pharmacy and Provings; but instead of that, sir, I hear a report here on physical science—physical science, and not Materia Medica. The first part of the report appertains entirely to physical science and the presence of medicinal substance in certain attenuations. It gives no relation of those substances to any morbid condition of the organism whatever. And so, therefore, I am somewhat disappointed in the report, although, from the caption of the several papers, I should not have been.

Again, sir, I find in the other department a report of a series

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of clinical cases properly belonging, I presume, if the chairman will allow me to make the statement, properly belonging to the Bureau of Clinical Medicine. According to this, therefore, we have no Bureau of Materia Medica, Pharmacy and Provings before us for discussion.

This is pharmacy without a pretension to pharmacy. If this is pharmacy, then we have no comments perhaps to make. But this is simply a report upon physical science; the report relates simply to physical science and nothing else. I had expected, Mr. President, from the character of the gentlemen engaged in making this report, that we would have had something else, or something said in relation to drug action, and to the action of drugs on the organism, what tissues are affected by drugs, how they are affected by drugs, what are the results of these effects, and from that, an inference as to the power of drugs in disturbing the functions of the organism. But not one word has been said upon that subject. If I understand the papers correctly, I believe not one word has been said upon that subject.

The chairman of that bureau did, in a paper which he read, refer to this matter, but they did not appertain to the papers proper of the bureau. With all credit to him, he has relieved the bureau from an onus which I think could properly attach to it under the circumstances, that is, of not making a proper report of Materia Medica. First, we should know where the drug impinges, what tissues are disturbed, whether the irritation occurs within the blood, whether it occurs within the nervous system, and if in the nervous system, which class of nerves it disturbs. Is it the cerebro-spinal, or the sympathetic, or the organic, or the vegetative? These are the points really which this Bureau of Materia Medica ought to make. When we can establish a basis for their action, and a uniform prescription, a uniform dose may be more nearly approximated. But until we can lay the foundation for uniform drug action by attaching that action to certain tissues of the body, we utterly fail to perform the duties which we owe to the homœopathic medical profession. Until, I say, we can accomplish this, we utterly fail in the duty we owe, as teachers and students of Materia Medica, to the homœopathic profession. I believe, sir, that we will have to go back and restudy many of our physiological problems, and some of our histological problems, and when this is done we shall be able to draw conclusions from the facts there stated quite diverse from those offered by our old-school physiologists and pathologists; draw conclusions which will lead us in quite an opposite direction, and afford a beacon-light which will lead us onward to the study of true homœopathic Materia Medica. I am sorry that I cannot say that this bureau has furnished us a stepping-stone to this

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field, or taken the first step in that direction. It has only proved that certain medicinal substances are inert when given in the 1,000,000th potency, which was known thirty years ago.

J. H. McClelland, M.D., Pittsburgh, Pa.: I cannot say that I am discontented with the report of this bureau. In the first place, I read on the circular, that it was to be a report of the Bureau of Materia Medica, Pharmacy, and Provings. In the second place, I read that the bureau, as was their right, selected a certain subject, and that subject related to the proof of drug presence and power in attenuations above the 6th decimal: first, as furnished by the tests of chemistry; second, as furnished by the spectroscope and microscope; third, as furnished by the tests of physiology; fourth, as furnished by analogy from the field of impalpable morbific agencies.

Secondly, the proofs of medicinal presence and efficacy in attenuations above the 6th decimal: first, as furnished by the tests of clinical experience, in the use of attenuations, ranging from the 6th to the 15th decimal; second, as furnished by clinical experience, in the use of attenuations, ranging from the 15th to the 30th decimal; third, as furnished by clinical experience, in the use of attenuations, above the 30th decimal.

Now, you might as well expect the Bureau of Surgery, after it had selected the subject of tumors, to bring in a report on fractures, just as well. I think no one will doubt that this bureau has adhered strictly and logically to the subjects selected by the bureau, and which it had a perfect right to select. Next year they may take up another phase of Materia Medica. This year the subject was certainly very ably handled, and in reference to that report I would like to say one word. We have a good deal of testimony, as I remarked yesterday, in regard to another paper, of a negative character. We have testimony here that finds no drug in a certain potency, but that is evidently negative testimony. It proves that no drug was observed in that potency, perhaps, with the means at hand very ably handled. It does not prove that these potencies are without power, as one of the papers would lead us to believe. The positive testimony, which each and every one has had, that the potencies above a certain grade, the 30th or higher, have produced effects positively, is worth all of the negative testimony that could be adduced. But I can very readily see myself why it is that the testimony that has been offered in regard to the wonderful efficacy of the higher potencies, is received with doubt. It is because, in many instances, the enthusiasm of the reporter has carried him away really, or at any rate, has blurred his judgment. We have testimony that is absolutely defective, we have testimony as to the cure of pa-

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thological conditions, that any one knows must be absolutely without foundation—without truth.

When I find, for instance, a case of typhoid fever reported, and a most frightful state of things existing, the patient just at the last gasp—a case of genuine typhoid fever—just as you all know, with certain pathological conditions produced. Now then, a certain potency is given, and very often a very high potency, and lo and behold! the next time he is visited, in twenty-four hours, the patient is well. Now we all know, every one knows, that that cannot be. It cannot be. You appeal to people that ought to be reasoning people to believe things that cannot be. So we find tumors described, malignant tumors, and a high potency is given, or a low potency, as the case may be, but I really think the high potency is oftener mentioned. A high potency was given, and under the influence of that drug administered, a cure is reported. We know that a morbific growth is a thing of slow growth. It is something which is developed after months, and months, and years. When we hear the reports, we find that one dose is given, and LO! *the next day it is gone!*

Now, that, I say, shocks the faith of the people in the testimony that is brought to bear as to the efficacy of high potencies. On the other hand we all know that we have given the 30th potency to the 200th potency and higher potencies, for conditions of disease which we cannot solve, we cannot limit; the conditions were progressing; and under their action, in a reasonable time, the case has recovered, evidently as an effect of the medicine. Now I say, there is nothing in that testimony to convince us that there is potency and power in these 30th potencies, and higher potencies, to do such things.

DR. P. P. WELLS, Brooklyn, N. Y.: Ladies and gentlemen, I have but one word to say in reply to the statement which has just been made by my friend, Dr. McClelland. I am about to state what happened under my own eyes, and I know it is not what another has told me. It is not what another has done. I will give you the facts, and you can make up your judgment as to them. The patient was a little girl, nine years old. She was in a state of constant delirium, with intense headache. If she was asked a question she would answer it immediately, and then fall off into delirium. When questioned she declared that the pain in her head was intense. She had a severe cough with an excruciating pain through the whole chest. She had tympanites and tenderness over the whole abdomen, with diarrhœa of a brown watery substance, which was running her into the grave. Now you may call it typhoid fever or whatever you like. But

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that little girl got a half dozen pellets dissolved in a teacupful of water. I observed that myself, and I know. This dose was given at 4 o'clock in the afternoon, and at 9 o'clock the next day she was sitting on the sofa dressed.

SEVERAL MEMBERS: What remedy was given?

P. P. WELLS, M.D.: I will tell you if you want to know. But that was a perfect picture of typhoid fever. That was it. The patient recovered. She was up and dressed, and sitting on the sofa. The dose was administered between 3 and 4 o'clock in the afternoon, and at 9 o'clock the next morning she was up and dressed. Dr. McClelland is mistaken as to its being possible or impossible. That which has been is certainly possible. I think we must stick by that. Now as to the susceptibility which is sometimes met with to medicinal action, a great many of us have got a great deal to learn. You have been told about the effect of a shrub. There are other medicines and vegetables which produce the same effect. If a vial of a certain medicine were uncorked and held to the noses of certain parties they would be thrown into convulsions in a minute. I have heard of an experiment that was made upon a young man which showed his extreme sensibility to drug action. Upon inhaling the medicinal substance he was thrown into convulsions. This only shows the extreme sensibility of this young man. This is found to be the case with certain persons. They are extremely sensitive.

But now I will go back to what I know myself. A patient was sent to me from a physician in New York, with a statement that she was extremely sensitive to medicinal action. The action was something singular in her case. I put a vial under her nose with pellets in it, and she went into convulsions in a moment. Now I am perfectly competent as a witness to this fact: first, that it was a vial; second, that it had pellets in it; and third, that she went into convulsions; fourth, I know that the cork was in the vial; fifth, I know that it was put under her nose; and sixth, I know that she went into convulsions just as quick as the vial came under her nose. I will speak of another thing in this patient. I would only say that things have happened to some persons that have not happened with other persons in this world, but that does not prove that it did not happen. Her susceptibility was so great, she would take a pellet in that way and be affected. She would say, "Now, doctor, I feel it going up my left arm." I gave her the medicine, and I know what it was. When it was administered, she would say, "Now, doctor, I feel it going up my arm," and she would put up both arms over the phrenological organ of hope, and say, "I feel as though all my

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hope was gone out of me." I gave Pulsatilla, and her symptoms are almost a literal translation of Pulsatilla as they stand in the Materia Medica.

HENRY E. SPALDING, M.D., Hingham, Mass.: I would like to ask the duration of the sickness before the single dose was given—I refer to the case of typhoid fever—and what remedies had been given before that, in the treatment of the case.

THE PRESIDENT: The time of Dr. Wells has been exhausted. Dr. Brown, of Binghamton, has the floor.

TITUS L. BROWN, M.D., Binghamton, N. Y.: Mr. President, I have listened to the papers this evening, of this bureau, with a great deal of pleasure, and I am satisfied, as far as I am concerned as a member of the Institute, that they were well-presented, well-written, and well-delivered papers in fact, and a credit to the Bureau of Materia Medica, and the cause of homœopathy. They simply gave individual opinions according to their observations. Be they correct or not they gave them as correctly as they could. Low or high, their opinion was given to us as well as any one could give it. I think they are entitled to great credit for presenting their views fairly to us. I do not make any criticism upon the bureau or upon the papers. I rise simply to throw in a thought in reference to the action of remedies upon human bodies. You will all acknowledge that they produce poisonous effects, and produce subjective or objective symptoms, and then they produce changes of the tissues of the body. You will find afterwards just exactly how they do this. This must be ascertained, of course, by discovery—this other physical action. I cannot see any difference between their physical and dynamical action. They are forms of matter, we are forms of matter, and if we take into consideration their condition and the results that they give, we can tell uniformly what the result will be. I have never found that I could substitute one remedy for another. I have found that I could cure the patient of a certain condition after having obtained the exact remedy. When I had a sufficient number of cases I had something to found the remedy on. In the same case you can repeat the same remedy. We can repeat the form, not always absolutely. You will only get a similar form—similar motion. This can be done by the action of remedies. I never produce the same effect, only a similar effect. Now what is this dynamic action? Is it not physical action but beyond our consciousness, whether it be a subjective symptom or objective symptom? We report results with our symptoms on one side or the other, which are very often very hard to make out, because we do not understand them, and then we fall back and give credit to all degrees

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whether of low or high dilution. The effect of the dilution is simply the action of remedies. You may give them any name you please. It is matter in contact with matter. By no possibility can you destroy any portion of the remedy. Now, for instance, I hold here in my hand a tumbler of water, pure water; from above comes a stream of pure water running into it, or you may suppose it is running into as large a vessel as you please. I put medicine in that water. How long has that water got to flow until the medicine is exhausted; until it has reached a point when it will give no dynamical action? So with the action of remedies we may criticise, but our object is to learn. That is the object I had in coming here.

O. P. Baer, M.D., Richmond, Ind.: Mr. President and gentlemen, I am very glad to say that I recognize the fact that there are four kingdoms in the physical universe, an elementary and mineral, and a vegetable and animal. Most scientists claim but three, but our elementary is as large a kingdom as the rest. Homœopathy claims a portion of all these kingdoms, hence it is a physical science. Of all physical sciences it will in time be the most exact.

Now to prove some of its peculiarities. Do you not all recognize that everything in the physical universe has a form peculiar to itself, or it has some peculiar characteristics peculiar to itself? But has not everything an identity? Most assuredly everything has an identity. How do you know one from another except by its peculiarity, by its identity, by the law of comparison, by its peculiarities. It being the case that there is that identity, is it not always manifest by simple presence, or an external physical presence, a proximate presence? Sometimes this presence, whatever it is, does not come to your view; it is neither tangible nor observable. Everything has a sphere of action. Do not minerals have a sphere passing off from themselves? Do not the elements have a sphere? Do not the vegetables, and does not the animal kingdom? Everything, if you please, has something peculiar to itself, flowing out from itself; everything is influenced by that flowing out, everything surrounding it. It is its own self. It is like a grain of musk sending out its effluvia in every possible direction. So it is with every element of the vegetable, mineral and animal kingdom; they all have their characteristics. These characteristics are emanations of its life. Now this identity, I hold, you cannot destroy with all the preparations possible. There is an inherent principle within the form of the thing, seen or not; it is itself, its life. That gives it form. Life is force. Force pushes as life pushes forward and gives form to matter. The life within it is the power that that life contains. This in-

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trinsic value belongs to it; it is that power which no dynamization can destroy. It is there; it is an inherent principle, inherent with the body itself that gives it identity, having, like it, a power. It may be like the musk in the tower of Pisa, that has existed for eighteen hundred years; there it is. Its presence can be perceived; it is not destroyed. Its atoms may be separated, but they are never entirely destroyed. What are the atoms? They are the most obtrusive and the most intrusive materials in the physical universe. Each atom seeks its affiliate, it seeks union. Very often we have a great combination of them, forming a molecule. This molecule is formed into masses; then they become inert; it is a finite, which is so active; it is a finite, which is so obtrusive, and as you reach the finite you reach power. It is that power which gives homœopathic medicines their virtue.

Now I don't care how much you talk about low or high dilution, the thing we want is the picture; the thing we want is that which directly corresponds to the picture presented by your patient. You have a certain class of symptoms, and you search your Materia Medica for a remedy that corresponds precisely, or, in other words, is a prototype which the symptoms present. There you have a fac simile, one with the other; one is the prototype, and the other is the type,—one is the picture, and the other is the image of that picture. Make your prescription and you succeed.

There are a few other things that I wish to speak about. One is an interesting case that I had. I was called to see an exceedingly singular case; it was a banker's wife. I was called between two and three o'clock in the morning. When I went in I found her in a perfect state of frenzy and excitement. I said to her:

"What symptom is the most prominent, can you tell me, can you pick it out?"

She told me: "Oh, I have such a very sore pain in my urinary organs; I want to urinate every minute, and I can't."

I at once took out my case of 200ths and gave her five or six pellets of the 200th of Jenichen's dilution of Cantharis. I gave her this to take; she took one teaspoonful.

She said: "It will not do me any good."

In less than five minutes she fell asleep. She slept for fifteen minutes, when she raised up, and I gave her a similar dose again. She told me she had no more pain. I visited her the next morning at ten o'clock, and she was about her usual work.

Dr. Pearson, Washington, D. C.: Mr. President, ladies, and gentlemen, I will not detain the Institute five minutes. I do not intend to enter into the discussion of these papers at all, but

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I am thankful for small favors. I really feel like congratulating the worthy chairman of the bureau, and the members of that bureau generally, with what I regard as being very important, if not the most important papers ever offered to the Institute. Last year the papers offered on that occasion were good. The papers did remind me a little of the story told by Mr. Lincoln. On one occasion he was obliged to listen to a long essay on some moral subject with which the writer and reader were very familiar; and when he got through, and asked Lincoln's opinion of it, Mr. Lincoln said he thought that anybody that liked that kind of thing would be apt to like that kind of thing, and he would like that paper.

Mr. President, I could not help thinking of that anecdote, and I compared the members of this bureau to the unruly church member, who was eternally backsliding and as often being brought into the church and baptized over again, until a sailor suggested that the only way was to put him in and keep him in over night.

You will remember, Mr. President and gentlemen, that on that occasion I predicted that there was to be a reformation of this kind. I must confess I was sold on that occasion, but I felt just as good as a Methodist preacher in camp-meeting.

T. C. Duncan, M.D., of Chicago: I move that this bureau be closed.

The President: We will hear from Dr. Dake first, as he is the chairman of the bureau.

Dr. J. P. Dake, Nashville, Tenn.: Mr. President and gentlemen, I will endeavor to close it up very rapidly. In the first place I wish to correct my friend Dr. Lilienthal with regard to Dr. Allen's experiments. The bureau never represented to Dr. Allen that Dr. Sherman should make the preparation; they never proposed that to him at all. The proposition was that these preparations should be made in this city by a committee, as I stated in my introductory.

My friend Dr. Small was not present when our papers were read; if he had been he would not have made the speech which he made here a few moments ago. He says he don't want chemical provings. Now those gentlemen who heard our papers know very well that we did not insist or limit the proving of medicines to chemical tests by any manner of means. Indeed, we went far beyond that, even into physiology, and even into the sick-room.

Now I am perfectly satisfied with what this bureau has been trying to do, and I will briefly recapitulate its work.

This bureau presented, last year, first a history of Hahne-

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mann's object and methods in drug attenuation. I challenge any gentleman to successfully contradict the statement made in the first paper giving this history. It was correct.

In the second paper we gave the history of drug attenuation as practiced by the followers of Hahnemann since his time, with a special reference to deviations from his method. I say that the statements made in that second paper are correct, and when they are objected to I will be obliged to any gentleman if he will point out to the author of that paper the misstatements of history.

The third paper presented was the means and methods of drug attenuations with reference to impurities and errors; and this paper was very carefully prepared, stating the means used and the methods pursued, with the dangers of impurity and inexactitude and evil in our pharmacy. It was a valuable paper, as you will believe when you read it; when you see it in print you will appreciate it. That was as far as we were able to go last year on account of the want of time. We then deferred, as I mentioned in my introductory, the remaining sections of our subject over to this year. We have presented papers on this subject to-day. We have adhered to our subject, we have stuck to our text, and I believe you will agree with me that we have not wandered away.

We have to-day presented the evidence of the presence of drug medicine and drug power in homœopathic attenuations. Have we endeavored to disprove or to tear down? Not at all. We have endeavored from all quarters to abide by the tests developed by these proofs of drug presence and drug power in drug attenuations, in the 1st, 2d, 3d, 6th, 12th, 30th and 200th potency, and as much further as the test can possibly go, be it in the physiological laboratory, or be it in the sick-room.

Now we have endeavored most faithfully to adhere to our plan; we have done it with the best of feeling in the world, wishing to upset no man's faith. We don't know whether we shall stand or fall in this body, but we have worked for the profession alone; we have worked for homœopathy and for the medical world and the world outside. If we wish to know anything in regard to drug attenuation we have to study to find it out. That is what we have been endeavoring to do, gentlemen, and we have done it, as I have said, with the best of feeling, and we are happy as a bureau, and now feel that even those who differ with us within the bureau, as you have observed by the papers, we are happy to say that a good feeling exists all around, and I believe we have never in the Institute had a meeting where this bureau has ceased to do its work with more satisfaction to all concerned. I will not repeat. (Tremendous applause.)

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T. C. DUNCAN, M.D., of Chicago: I renew my motion to close the bureau.

DR. HAWKES, of Chicago: I rise to a question of privilege. My name was mentioned in one of the papers, and it has left a misapprehension on the minds of my friends in the Institute. This would be the case if that matter was not cleared up. The intimation was made, or impression given, to some of my friends that I had been afraid to make a test. My reasons were these, and I think they are good ones: that in a matter of such national, such world-wide importance as the settling of a question of potency, that it was too great to be placed in the hands of less than representative men. In proof of the correctness of my assertion, the very first report of that bureau, that is, of the Milwaukee test committee, contained two gross errors in connection with my name. One was a positive misstatement, and the other was an implied misstatement. These facts I pointed out in a subsequent statement. I think that this also will give the reason why Professor Allen dropped the matter where he did. My friend, Professor Allen, I think will give the same reason.

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REPORT

OF THE

BUREAU OF CLINICAL MEDICINE.

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S. LILIENTHAL, M.D.,	New York, N. Y.
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SCARLATINA.

ITS HISTORY, ETIOLOGY, AND VARIETIES.

By C. Pearson, M.D., Washington, D. C.

HISTORY.

Concerning the history of this disease we find very little in medical literature. It was known to Sydenham over two hundred years ago, and he spoke of it as being "nothing more or less than a moderate effervescence of the blood (whatever this may be) arising from the heat of the preceding summer," though he had previously stated that it might occur at any season of the year, leaving us to settle this incongruity as best we may.

A pestilence described by St. Cyprian over 1600 years ago, was very possibly malignant scarlet fever. He says the patients suffered from "despondency, debility, involuntary evacuations, *inflamed mouth*, swollen stomach, and sparkling eyes." So far as we know it prevails in all countries,* and at all seasons, though like all other cutaneous diseases it is more prevalent in the late autumn, winter, and early spring than during the heat of summer.

THE CAUSE

Of the disease is, like that of most if not all others of an acute character, entirely inexplicable.

Long before the discovery of vaccination the animal origin of cutaneous diseases had its advocates, and since we have had the malarial, the electrical, the gaseous, the atmospheric, the fungous,

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* Though forty years ago it is said to have been unknown in Australia.

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and latterly the germ theories; each of these will serve its advocates as an explanation as long as it will apply to any given case. In reference to the malarial Caldwell says: "If asked what it is, I answer I do not know." Watson says: "It is a specific poison, producing specific effects on the human body, but of its physical or chemical qualities we really know nothing." Armstrong says: "We are utterly ignorant of the nature of this poison, the circumstances under which it is generated, or its effects on the human body."

But we now hear of nothing but germs. They seem to be responsible for the origin of all zymotic diseases, and from the confident way in which some physicians speak of them one would infer that in some localities they are at times so plentiful that they might be gathered and measured out like clover-seed by the peck, and yet, who has ever seen one as a developing cause outside of the diseased organism, or if at all, anywhere, only after the disease is sufficiently developed to lead us to believe that they are more likely to be a result than a cause? When will we cease to follow the blind lead of the allopath in mistaking effect for cause? And yet there is a cause or a combination of causes for every effect, but in this case can the microscope reveal it? Can the finest chemical test detect it? But from the effects we know that a cause is operating as favorably for the germination and growth of the disease, as are heat, light, moisture, and a prepared soil to that of a plant that is indigenous to certain conditions. The cause is not alone atmospheric; the condition of the system undoubtedly has much to do with it, and in this, as in everything else in nature, whenever conditions are favorable you witness certain results.

That the disease is highly contagious there can be no doubt. In one instance I feel assured of having carried it in my clothing six miles to my own children, and yet sporadic cases must originate in some other way, and who has not met with them? I once saw three cases within twenty-four hours of each other, and at least half a mile apart, the children not having been nearer to each other, and no case of the disease had been known to exist in that vicinity for three or four years previously, but in a few weeks afterwards there were probably fifty cases in the neighborhood.

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What was the cause? It was in the winter, the atmosphere clear, cold, and to all appearances healthy, but the proper conditions for its development existed, and the result was scarlet fever. And this combination of causes not only generates the disease, but its modifications give rise to its different types, though this is probably more dependent on the state of the system or to a certain idiosyncrasy of the patient than upon the operating cause.

The disease is usually divided into three varieties: *scarlatina simplex*, *anginosa*, and *maligna*. It is not necessary to describe these; you are all familiar with them, not being raw recruits or medical students, but veterans, who have met in its native lair this hydra, and I may say, conquered it, too, not as the fabled Hercules is said to have overcome the serpent of Lerna by cauterizing its mutilated necks with fire-brands to prevent other heads from growing, but with the invisible, indomitable homœopathic agent that is as potent to cure as was the impalpable cause to produce it.

But within the past two years a disease has come under my observation called by the physicians of our city scarlet fever, about the nosology of which I am not fully satisfied.

It is extremely rapid in its course, running from one to four days, and usually terminating in death. A child, seeming to be in good health, is suddenly taken with vomiting, and very soon with purging also, the pulse is quick and weak, temperature not much more than normal. In from six to twelve hours the vomiting usually ceases, the evacuations from the bowels become involuntary and at longer intervals, the child becomes unconscious, and after from twelve to twenty hours rarely, if ever, speaks or sleeps; the eyes are not closed, the pupils are dilated, and the balls move from side to side, though there is no evidence that the patient either sees or hears. There is great restlessness, constant tossing and desire to change position, with hurried and sighing breathing; no great thirst, though there is no trouble in swallowing, and no swelling or other evidence of sore throat; the tongue is only slightly furred, and not unusually dry, and the breath is not at all fetid; there is little or no rash; a slight redness is sometimes observed about the joints of the extremities, and

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the whole body turns purple, nearly black, a few hours after death, in fact, this discoloration often sets in some time before, so that it might be said the patient commences to die as soon as it is found to be sick.

One case of a stout, healthy-looking little girl, eight years of age, I saw twenty hours after being attacked, and five hours before death, and noted the following: Pulse 160, temperature, 103, respiration 72 in a minute, with all the other symptoms I have enumerated.

This case I reported as one of cerebro-spinal meningitis, though there was no contraction of the muscles in the cerebro-spinal region, or any other evidence of spinal irritation. Two other children in the same family, similarly affected, had just died under allopathic treatment, and others in different parts of the city at different times, all of which, so far as I could learn, were reported by the attending physicians as scarlet fever. My own impression is they were mistaken, or if not, it is a form of the disease about which little or nothing has hitherto been said or written. It more nearly resembles spotted fever, yet lacks many of the characteristics of thatdisease.

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SCARLATINA.

THE DIAGNOSIS AND COURSE OF ITS VARIETIES, PROGRESS, AND PATHOLOGY.

By S. Lilienthal, M.D., New York.

The Bureau of Clinical Medicine is ordered by its chairman, Dr. C. Pearson, of Washington, D. C., to prepare papers on this so often fatal disease, and prevailing constantly in our midst. Is there anything new under the sun, which has not been written and discussed by the different schools of medicine? Is it worth while to incumber our *Transactions* by essays, which can be studied with better advantage in Ziemssen's *Encyclopædia*, in Reynolds's *System of Medicine* (Hartshorne's edition), in Kaposi's *Diseases of the Skin* (1880), not to speak of the various works on diseases of infants (Gerhardt's *Encyclopædia*, Ellis, and others). I might speak of my own personal experience, a large one in scarlatina, and I would have only to confirm the statement of better writers; I would have only to acknowledge that, notwithstanding faithful attendance, I lost cases in every stage of the disease, and it was very little consolation to me that the same happened to other and better, but not more zealous, attendants. I even doubt that such a thorough homœopathist, and such a thorough scholar of homœopathic Materia Medica, as Adolph Lippe is known to be, can tell us anything new about the treatment of scarlatina, after having studied the exhaustive article of P. P. Wells, which first appeared in the *American Review*, and was rewritten for the *North American Journal of Homœopathy*, vol. 24, new series, vi, p. 349.

After this short introduction let us go to work.

Scarlatina (*febris scarlatinosa, Scharlach fieber, fièvre scarlatine*) *is an acute, contagious, febrile affection, characterized by a simul-*

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taneous inflammatory affection of the organs of deglutition, and scarlet-red exanthem of the skin. (Kaposi, 201.)

The course of the disease may be normal (typical) or abnormal (atypical). Its four stages are that of *incubation, prodromal, florition, and desquamation.*

The *period of incubation*, preceding the eruption of the rash, and beginning with the moment of infection, may last from less than twenty-four hours to three, and even five weeks, its probable average being from four to six days. Health may remain perfectly undisturbed during all this time, or there may appear a few days before the prodromal stage sets in, some malaise, a febricula, and dulness of head.

The *prodromal stage* begins with sudden and severe fever; the temperature reaches 40° C. (104° F.) and over, pulse 140–160 to the minute, even on the first day of the attack. Children may vomit, and severe vomiting prognosticates a severe throat affection. Simultaneously with this high fever appears the angina, redness and swelling of the tonsils, soft palate (with marked dark-red spots), extending more or less intensely over the mucous membrane of the fauces and hard palate, still more rarely invading the nasal cavity, larynx, trachea, and conjunctiva; the tongue is heavily coated. Subjectively we meet difficulty of swallowing, malaise, thirst, nausea, moderate headache, or the concomitant symptoms are already grave, as vomiting, sopor, convulsions (in children), deliria, as symptoms of severe co-affection of the entire nervous system.

After twelve to twenty-four hours the eruption shows itself first on the anterior neck and clavicular region in the form of closely standing dots, pale or bright red, which, seen from a distance, appears as a diffuse redness. The face, though somewhat red and turgescent, hardly ever shows any eruption, and the paleness around the mouth is characteristic of the disease.

During the *stadium floritionis* the exanthem spreads over chest and back, upper and lower extremities, being especially developed on the back of the hands and feet, of pronounced scarlet tint, most intense at the centre of the dot, fading towards the periphery; confluent by their margins, so as not to leave any skin of normal appearance between; not elevated to the touch; com-

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pletely disappearing under pressure and rapidly reappearing when the pressure is removed.

On the extremities we may find some interruption in the continuity of the exanthem. It reaches its acme on the second day, remains stationary one to three, sometimes five to seven days, during which time the intensity of the redness frequently changes, especially with the exacerbations and remissions of the fever. The general symptoms and fever continue, the angina may remain moderate, diffuse redness, moderate œdema of velum and uvula, but in other cases we meet an intense tonsillitis, especially dangerous in children. The buccal mucous membrane of diffused redness; the tongue, after casting off its gray coating, showing its dark-red papillæ (mulberry tongue, cat's tongue); the cervical glands tumefied. The skin is dry, hot, burning; urine scanty, frequently containing albumen and renal epithelia. The exanthema, after thus remaining from one to three days at its acme, paler from the neck downwards, and though the fever and concomitant symptoms decrease, the angina remains in *statu quo* or even increases. After the rash recedes (four to eight days) some yellowish-brown pigmentation remains, the skin becomes of normal temperature, transpiring, angina and all the concomitant symptoms pass off, sleep and appetite return.

Stadium Desquamationis.—With the disappearance of the rash desquamation begins in a day or two; the chin, sides of the neck, and upper part of the chest are mostly the parts first to desquamate. Where the cuticle is delicate, it becomes everywhere scurfy and is so thrown off; where thicker, it is raised and removed in small isolated patches, which increase in size by a continuous desquamation of their margins until they meet and so leave the whole surface desquamated; and, lastly, where the epidermis is very thick, it is undermined in large flakes before it is cast off (desquamatio furfuracea, siliquosa, membranacea). Duration of desquamation from a few days to a month or two. Alopecia, or turning gray of the hair, has been sometimes observed.

Such is normal or regular scarlet fever, corresponding to most cases in benign epidemics or to sporadic cases in otherwise healthy

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persons. But scarlatina shows more frequently than any other exanthema deviations from this normal course.

The incubation may be unusually short, four to five days, more rarely abnormally long, lasting several weeks; the latter in rachitic and marastic children. The prodromal stage either absent or at least a febrile, and the angina yet so slight that it may be easily overlooked, and the eruption sets in without hardly any prodromal stage, irregularly, first on the trunk, over the joints, on parts kept warm, or pressed, or irritated, or scanty, or according to some observers only on one side of the body, gradually and delaying, or suddenly spreading over the whole body. It is either absent on paralytic parts or, on the contrary, more fully developed and longer remaining.

In some cases the eruption only stands out for a few hours, so that it may be easily overlooked, and only the tonsillitis and the concomitants hinting to the contagion, eventually the sequelæ (renal affection, hydrops) prove the character of the disease. Hence we read of a *scarlatina sine eruptione*, with complete absence of the exanthema and desquamation, but presence of angina and concomitants corresponding to scarlatina. Even such cases may lead to a fatal issue.

On the contrary, the eruption may remain out for an unusually long time, for several weeks. It turns pale, then recuperates again, but the dots are now of a darker tint, from the exudation of hematine. The dots then fail to disappear under pressure; even petechiæ may now be detected. Even relapses of the exanthema, after nearly finished desquamation, are reported, but this is more an erythema then a genuine scarlatina. Desquamation may also set in very late, may be unusually prolonged and very intensive, *i. e.*, come off in large and thick flakes.

In relation to the morphological qualities of the normal eruption, *scarlatina larois*, we may consider as deviation *scarlatina lævigata*, where the dots appear more salient and shining; *scarlatina papulose* and *miliares*, with formation of nodules and vesicles on the diffusely reddened skin; *scarlatina variegata*, with the formation of larger spots emanating from the solitary red dots, with decided differentiation by their darker tint from the other surface, covered by the paler eruption; *scarlatina hæmorrhagica*

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seu septica, with exudation of blood, at first punctiform, then spreading to the size of a silver dollar or the palm of the hand, and over wherever the exanthema is found, in children mostly on the trunk, in grown persons on the neck and over the joints, in conjunction with scorbutic affections of the buccal mucous membrane,—a very malignant type.

There cannot be any doubt that the virus of several exanthemata may be simultaneously taken up to develop their specific action, the one appearing on the surface when the other is already in stadio decrementi. Thus measles or small-pox may follow scarlatina. Erythema, urticaria, solitary vesicles, and pustules may appear simultaneously with scarlatina, but must be considered as a local increase of the filling of the bloodvessels, or an exudation and permeability of the walls of the vessels. Chronic exanthemata, scabies, eczema, psoriasis retire during the efflorescence of scarlatina into the shade, and take up their activity again with the progress of reconvalescence.

The series of further anomalies which scarlatina offers varies according to the different local and general symptoms. Each of them may, by abnormal development, take front rank and essentially change the complex of symptoms, its course, and issue. Such abnormal symptoms appear either as *complications* or as *sequelæ*.

Most frequently is an abnormal intensification of the scarlatinous angina—*angina scarlatinosa maligna*. During the prodromal stage, and at the beginning of the eruption, we meet already a parenchymatous inflammation of the tonsils, of the mucous membrane of the organs of deglutition, and of the retromucous connective tissue, high-graded difficulty of deglutition, the mouth stands steadily open and saliva flows copiously from it, high fever, bloatedness of face, restlessness, deliria. The enormously enlarged tonsillæ lie closely together, and may cause suffocation. The formation of abscesses on one or several places is a rather favorable issue. More dangerous is suppuration of the retromucous connective tissue. Retro-pharyngeal abscesses may, either directly or indirectly, by burrowing of the pus and infiltration, or in consequence of it, lead to a fatal issue. Rapid death may be looked for where the inflammatory infarct of the

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tonsils and of the mucous membrane leads to gangrene, evincing itself by the foul breath, which, emanating from the tonsils, spreads itself over velum, mouth, fauces and nares; coma, convulsions, ichorous discharge from nose and mouth, filiform and rapid pulse; death ends the scene. The exanthema remains out during the intensive fever accompanying the gangrene, and greater only with the weakening of the pulse.

Another time it is the *diphtheritis of the fauces—angina diphtheritica*—which aggravates the angina. The dirty-yellow fibrinous deposits may expand from the mucous membrane of the fauces through the choanæ to the Schneiderian mucous membrane. Frequently this exudation, firmly adhering like a membrane, gets dissolved.

More dangerous is the diphtheritis extending to the larynx—*laryngitis crouposa*—which may become fatal through suffocation, an accompanying pneumonia, gangrene, or decomposition of the blood, or, even after the danger from croup has passed, through a secondary sudden paralysis of the nerves and bloodvessels.

All these affections are more or less regularly accompanied by *swelling or inflammation of the submaxillary and salivary glands*, which in some cases may increase to an extensive inflammation of the surrounding connective tissue. The maxillary and cervical region show a tense swelling, pushing itself towards the larynx and preventing the opening of the mouth. Abscesses form on different points, with decrease of the local and general manifestation, and the patient may get well, or a rapidly-spreading gangrene may destroy life by exhaustion, high fever, erosion of the large bloodvessels of the neck and fatal hæmorrhage, or the tumor may remain indolent in *statu quo* for months.

Affections of the *intestinal tract*, manifesting itself in benign cases by diarrhœa, may become deleterious by arousing a croupous enteritis, which, by its profuse, bloody-mucous discharges, may kill the patient, though the eruption looks well, by rapid loss of vitality and fall of temperature.

Otitis catarrhalis and *suppurativa* of the middle ear, perforation of the tympanum, followed by anchylosis of the ossicula, inflammation and caries of the pars petrosa, with complicating phlebitis and meningitis, with a tedious course or rapidly fatal

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issue, often complicates scarlatina in its early stages or appears as a sequela.

Every angina scarlatina parenchymatosa, gangrenosa or diphtheritica may become the source of manifold complications, principally of hæmorrhages, embolism, pyæmia, and metastatic inflammations in all tissues and organs.

There may be no particularly localized process, even angina and exanthema not excepted, or in the presence of an efflorescence of a hæmorrhagic character, the blood-poisoning caused by the scarlatinous contagion may destroy all vital function by decomposition of the blood. This gives us the *scarlatina typhosa, septica, hæmorrhagica.* According to the intensity of the symptoms we differentiate two grades:

In the first grade we meet immediately, with the beginning of the fever, great muscular lassitude and dulness of the head. In the stadium eruptions the manifestations of cerebral pressure increase; frequent vomiting, deliria, stupor, coma, convulsions, dilated pupils. Bronchial and tracheal rattling soon sets in, the tongue is red and dry, the abdomen meteoristic, the spleen moderately enlarged, urine scanty. The pulse, very frequent, becomes weaker, the temperature sinks, and death takes place after the disease has run its course, in twelve hours up to five days. In such a rapid course the exanthem either does not appear at all, or irregularly, or extremely suddenly, very intensively, in large, soon livid, or hæmorrhagic plaques.

In the second degree of scarlatina typhosa the manifestations of pressure in the brain are more moderate, the whole course of the disease more sluggish, so that the eruption develops itself regularly, though frequently mixed with petechiæ and miliary vesicles. Only at a later stage the morbid manifestations intensify. Albuminuria, meteorismus, and diarrhœa set in, and death may take place with coma, filiform pulse hardly to be felt, and sinking temperature. In such cases autopsies reveal gray granulations on the meninges, more frequently after a lutescent course of the disease, hyperæmia of the brain, of the lungs and intestines, swelling of Peyer's plaques, of the solitary glands of the intestines and of the mesenteric glands, finally serous accumulations in the cavities of the serous membranes.

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Renal affections are the most frequent complications of scarlatina, inasmuch as in most cases, though they may run a normal course, we may find, even during the early stages of the disease, some albumen and renal epithelium in the urine, even hinting to fatty degeneration. But in most cases the catarrhal and parenchymatous nephritis shows itself during desquamation and later, hence as a sequela of scarlatina, which may even then lead to a fatal result, though the exanthema itself ran its normal course.

Pneumonia, desquamative and croupous, the latter especially as a continuation of laryngeal croup, inflammation of the serous and synovial membranes, pleuritis, pericarditis, peritonitis, articular affections belong to the more rare complications. Keratomalacia appears in consequence of septic scarlatina and gangrene. Of less importance are epistaxis, aphthæ, suppuration of a maxillary or cervical gland, as long as they are only isolated complications of normal scarlatina.

We consider as *sequelæ* of scarlatina such affections as may have begun during the period of efflorescence, but which remain after desquamation, or which may develop themselves after the disease has run its course, but originated in the changes of the organism, peculiar to scarlatina.

To the first category belong long-continuing ozæna, as a simple chronic nasal catarrh or as a more intrusive inflammation, leading to ulceration, purulent discharge, caries, and necrosis of the conchæ and septum narium, erysipelas and even gangrene; otitis with all its possible sequelæ, destruction of important parts, residual difficulty of hearing or deafness, even caries, leading to death; enlargement of tonsils, chronic intestinal catarrh and consecutive disturbance of nutrition, metastatic affection of the joints and serous membranes, inflammation and suppuration of lymphatic glands, of the cutes and subcutaneous cellular tissue on most diverse parts of the body. Especially parotids and submaxillary glands swell up in an indolent manner, and may remain such as tumors for years; the same indolent swelling and infiltration of the periglandular connective tissue has also been observed all around the mandibula. From all these affections may emanate a chronic disturbance of nutrition, especially scrofulosis, or even an acute, fatally ending process.

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The most frequent and most to be feared sequela of scarlatina remains, the renal affection, which in rare cases, as well in the early stages as also later, may, as *morbus Brightii acutus*, lead to a fatal issue in consequence of uræmia, or develop later and gradually on different parts of the body, especially on the lower extremities, dropsical symptoms, and cause anasarca or ascites. Most cases with such a late dropsy are curable, others lead to grave complications, which may become fatal from hydrocephalus acutus, hydrothorax, hydropericardium, or œdema glottidis.

The *prognosis* of scarlatina is therefore always a doubtful one. I do not know a more treacherous disease than scarlatina, for the physician never feels himself on safe ground. At any time and in every case we may be surprised by the most dangerous symptoms. A case, normal in its beginning and running a typical moderate course, may suddenly turn fatal by uræmia, cerebral paralysis, or some other complication; or, after having run its course nicely, be drawn up for months by sequelæ and metastases, or become very dangerous and finally end in death. The physician needs to be constantly on his guard. We must not consider the most trivial complication lightly; we must never consider a patient out of danger till all the symptoms, even those which prolonged their presence even after desquamation, are fully removed, the urine perfectly free from albumen, and all the functions of the organism have returned to their normal state.

We must especially consider the course of the fever and of the exanthema. A high fever is always suspicious, still more its complication with considerable states of irritation or depression in the brain. A full eruption, developing itself at the right time, with moderate fever and catarrhal angina, allows the most favorable prognosis. Parenchymatous angina, inflammation of the cellular tissue of the mucous membrane of the fauces and throat are very dangerous states; diphtheritis, croup, gangrene nearly always fatal complications. The sudden disappearance of the efflorescence leads to intensive affections of internal organs, of the lungs or of the brain; tardy eruption, with continued high-graded fever and simultaneous cephalic symptoms, is of evil omen. Scarlatina variegata is often followed by an obstinate bronchitis and pneumonia. Scarlatina miliaris, characterized by

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the eruption of vesicles on the already existing exanthema, hints to pyæmic blood-poisoning. Solitary petechiæ, epistaxis, with otherwise moderate symptoms, are of no importance, but in company of high fever, deliria, sopor, gangrene, the precursors of general blood dissolution.

From the very commencement of the disease we must lend our greatest attention to the function of diuresis, and the urine ought to be daily examined for albumen. Albuminuria, as such, is not yet a dangerous symptom; it is hardly ever absent, but its presence holds before us the danger of uræmia, its consequent dropsies and a tardy convalescence. This and every other complication must be judged according to its pathological value and its possible consequences in relation to prognosis, and the same may be said of the sequelæ and secondary diseases.

The general character of the epidemic, and of the generic epidemicus, also offers some hints for the prognosis. There is in reality no such thing as a benign epidemic of scarlatina, and some epidemics excel in the multitude and dangerous character of its complications and sequelæ. When croup, typhus, cholera, dysentery prevail, even sporadic cholera has to be dreaded.

We must also consider the individual relations of age, of general constitution, of accidental complications. Younger persons run a greater danger than older ones, although even they may fall a sacrifice to the disease. Ill-nourished and ill-nursed persons, children liable to frequent angina, with infarctus tonsillarum, puerperal women, patients suffering from variola or typhus, or reconvalescents, run greater danger when attacked by scarlatina.

The *anatomy* of scarlatina teaches us nothing which we do not already know from the clinical picture. Hyperæmia, with moderate exudation in normal cases, with nodules and vesicles, a corresponding stronger exudation and cell-proliferation inside of papillæ and rete, in petechiæ, bloody exudation in the papillæ and cutis. The hyperæmia disappears in the cadaver. All other pathological,—anatomical changes,—which may be found, have already been mentioned in the clinical part of this essay.

The *ætiology* of scarlatina is no farther advanced than that of any other acute exanthema. There can be doubt that the cause

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of the disease is a specific contagium. By vaccination of blood, scales and secretions of scarlatinous patients, some severe cases were developed, and therefore such trials do not deserve repetition. It failed in other hands. Miguel is the only one who asserts to have thus gained immunity from further contagion. In the blood of rabbits, rapidly killed by injection of the blood of scarlatinous patients, bacteria were found in large quantity, but it is very questionable whether they have anything to do with the contagium. The contagium of scarlatina is volatile and fills up the respiratory atmosphere of the patients. Probably it may be also in the blood, in the epithelial scales of desquamation, in the excreta; it clings to vessels and objects, and may thus be conveyed to great distances. Breathing the air pregnant with contagium, direct touch of the patient and his excreta, communion with persons and things to which still clings the contagium, must spread the disease. Its tenacity against time and localization, against heat or cold and atmospheric changes, its long life, are facts acknowledged by most authorities. It is well known that healthy persons may become the carriers of the virus, and that it may be conveyed in letters, in clothing, in fact, in anything with which a scarlatinous patient came in contact. A house may be left uninhabited for months, still the contagium will tenaciously remain, and the first person inhabiting such a contaminated room, may catch the infection and fall a prey to it.

The contagium is not exhaled during the prodromal stage from the patient, the danger lies in the eruptive stage. Children, removed at that early stage from those already affected, may remain free from the disease. The power of contagiosity lasts longer in scarlatina than in measles, and even after desquamation is finished there remains still some danger as long as any sequelæ, like dropsy, is present.

The disposition to the scarlatinous virus is less than that to measles. We see, therefore, in a family only some of its members affected, while others escape. The morbid disposition is at its height between the second and seventh year, but no age remains exempt, perhaps senility. It is not yet decided whether the affection may be acquired in utero and the infant be born with it. Whether a person can be twice affected by the poison of scarla-

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tina, is likewise yet undecided, though such cases are recorded by trustworthy observers.

The frequent presence of scarlatina is sporadic, and it is nearly always found in large cities. Some believe that diphtheritis and scarlatina are correlated. Where many cases happen accidentally in one and the same neighborhood, the disease will spread by the increase of the virus, and we find thus epidemics of scarlet fever every three or four years in large cities, but they never reach such an extent as we meet in measles. Oscillating development and tardy extinction, a prolongation of its maximal stage, are characteristic of scarlatina.

The statistics of *mortality* differ between five per cent. and twenty to twenty-five per cent. of the affected, according to the pernicious or benign character of the epidemic. A disease showing great similarity to scarlatina has also been observed among our domestic animals.

So far Kaposi (Moritz Kohn), the son-in-law and assistant of Hebra; and certainly Vienna offered to him a great field of observation. What this writer puts down in terse and short sentences you will find in *extenso* in your Ziemssen or Gerhardt.

We may here be allowed to give some differential points, as found in Hall's *Differential Diagnosis*, page 26.

Trousseau remarks: In general terms it may be said that when the soft palate has a diffused red hue, similar to but deeper than that of the skin, while the tonsils are not involved; when with this there is a very hot skin, a very quick pulse, vomiting, a tongue with thick creamy fur, red borders and prominent papillæ, and with these symptoms exposure to the presence of a scarlatinal epidemic, the physician need not hesitate in pronouncing it scarlet fever.

A very early symptom of scarlet fever has been insisted upon as pathognomonic by Dr. Joseph Duggan. It is that the eye assumes a peculiar brilliant and glistening stare, very different from the liquid, tender, watery eye of measles.

The character of the preliminary fever often differs. In scarlatina it is marked and high, which distinguishes it broadly from

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diphtheria, which is apyretic at the outset; in measles it is of a catarrhal form.

In all the exanthemata the eruption makes its appearance in the roof of the mouth from twelve to twenty-four hours, and in many instances longer, before it appears on the cutaneous surface.

The temperature in scarlatina may reach 105.6°, or higher. It usually remains continuously higher during the eruption, and it is thus well distinguished from those affections with which, on account of other symptoms, it is most easily confounded, and more particularly rœtheln and measles. It begins to subside about the tenth day. Desquamation comes off in branny scales and in large patches. Occasionally the epidermis of the hands is detached entire and may be slipped off like a glove. This is true also of the feet. Sometimes several successive desquamations occur, frequently accompanied with itching, which in some cases is excessive.

Dr. Rinzer's observations go to show that, in the most severe cases, the temperature remains equally high all day; in less severe cases it remits a little in the morning and rises to a height between 3 and 8 P.M. A well-marked morning remission gives a favorable prognosis. The fifth, tenth and fifteenth days are those usually marked by a decided fall, and if after such decided fall the temperature again rises it indicates the development of some sequela, either an inflammation of the kidneys, throat, or one of the serous-membranes.

Urea is not increased, the chlorides are diminished. The phosphoric acid, after the first three or four days, diminishes even down to one-half or one-third its normal amount (Gee). Uric acid is retained during the fever and voided in excess on its decline. Bile pigment is present during the first six days.

Renal dropsy is a common and very fatal sequela. It occurs in about one-sixth of the cases. Albuminuria is usually the first symptom of the coming mischief. It may occur as early as the first week or it may not be found till the third. The twenty-second day has been found to be a common day for dropsy to make its appearance. With the albuminuria there is considerable

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pyrexia; the skin again becomes hot and dry; the process of desquamation ceases; the appetite is lost, the bowels become constipated, and in a day or two puffiness is noted about the eyes, followed by some œdema of the hands and feet, and these again may be followed by large serous effusions into the various serous cavities; the swelling and anasarca may increase; the urine becomes more and more scanty. If the urine be examined it is found smoky in appearance and highly albuminous. The microscope reveals blood-corpuscles, epithelial cells, and granular and epithelial casts. The relative quantities of albumen and blood sustain no relation to each other. Albumen may be abnormal, and blood corpuscles absent, or large quantities of blood may be present and only a trace of albumen. Dr. Basham points out that a bluish-green, tending to black, reaction with nitric acid and heat, is a grave prognostic, and indicates extensive renal disease.

Among the sequelæ there ought to be more stress laid on the joint-affections, which are sometimes very obstinate, and a scarlatinal vaginitis or muco-purulent discharge from the vagina is by no means rare, but it is often passed over, unless so severe as to compel attention.—*Ellis, Diseases of Children.*

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THE CONTAGIOUS NATURE OF SCARLATINA;

LIABILITY THERETO, AND EXEMPTION THEREFROM ON ACCOUNT OF AGE OR OF A PREVIOUS ATTACK.

By T. F. Pomeroy, A.M., M.D., of Detroit, Mich.

Of this subject,—scarlet fever,—that portion of it embraced in the above title has, by the chairman of this bureau, been assigned to me. I accepted the appointment with some reluctance and with many misgivings as to my ability to treat it with that degree of thoroughness that its importance demands; and although it is one much discussed, and one too that has elicited many and diverse opinions and conclusions, it must necessarily on this occasion be treated with the greatest brevity and incompleteness. I shall not, therefore, attempt a recital of the various opinions, views, and conclusions that have been reached in its discussion. Such an attempt would carry me through its entire history, and require a reproduction of the many and varied theories, speculations, and experiences of all schools of medicine in their observation and treatment of it. On the contrary I shall regard my subject mainly from the homœopathic standpoint, and possibly therefore from the only comprehensive scientific view of it. The suggestions and the teachings of our Materia Medica will partly supply the necessary data for this perhaps novel method of regarding this subject of contagion, and furnish the key that may possibly open to our view its possible simplicity and its harmonious relations with our therapeutic law, if not also with the requirements of general science. All homœopaths recognize the fact that the proving of drugs and of other therapeutic agents has opened up for our inspection the pathogenetic aspect of diseased conditions, where before such

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provings were made, and now to those who are unfamiliar with them, only a purely pathological one was possible.

Disease, however produced, must be regarded in the same general light and as falling under the same general definition, viz., as a disturbance of vital equilibrium, or of those forces by and through which life and health are maintained. However else we may regard disease in the abstract, we must recognize it only as a state or condition, an entity of condition, if such an expression may be allowed, for in truth conditions and relations are the real facts of life, those with which almost exclusively we have to do. So that it matters but little whether we regard it from a pathogenetic or from a pathological point of view, in either case the equilibrium of the vital forces is alike disturbed, and harmonious relations and conditions interrupted.

Having thus laid down the basis upon which I shall treat the subject of this paper, I will now proceed to the more direct consideration of it.

First of all a definition of the word contagion will be proper. The word contagion is derived from the Latin verb contingo, to touch, to bring in contact; this is its strict and literal meaning. For its definition as applied to disease I will take the one that I find in Chambers's *Encyclopædia*, which as concisely and as fully expresses its meaning as any other. "Contagion, the communication of a disease from the sick to the healthy, either by direct contact of a part affected with a disease or through the medium of the excretions and exhalations of the body." This definition comprehends its meaning only from a pathological point of view—the communication of disease through diseased conditions—while the full meaning of the word contagion is far more comprehensive, and may be briefly stated as follows: *Whatever* will produce disease through contact is contagious; this is the full signification of the word from its Latin derivative as applied to disease, that is, to repeat, whatever through direct contact will induce or communicate disease is contagious. This definition comprehends all possible modes of establishing diseased conditions, and it is the one that I shall follow in the illustration and farther consideration of my subject.

Before designating, as I shall do, only in a very general way,

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however, some of the modes whereby disease is communicated to the living organism, I shall proceed to a brief notice of two only of the more prominent theories that have been presented as the rationale of the manner in which disease is thus communicated, and these only from a pathological standpoint.

I shall dismiss the first of these with but a very brief notice, as it is manifestly the less tenable of the two, and this is the germ theory of the origin of contagious diseases. In the language of another, "this hypothesis . . . . . has its root in the fancy of the analogy that as seed cast on the ground yields, or may yield a certain harvest after its kind, as a field or garden plot may become fertilized by vegetable seeds or germs which may come to it borne by the atmosphere, or by other modes of conveyance, so the body may be infected with the germs of disease, which germs, being received in the body as a field for their reception, may increase and multiply in the body, and by their presence excite the phenomena which particularize all the special diseases of a communicable kind." This is the main feature of the germ theory of contagion; there are other features of it that I shall not stop to consider, as these are of less significance, but proceed at once to state the prime objection to the whole theory, and then come to a consideration of the other hypothesis to which I have already alluded. The fact that the analogy of vegetable fertilization is not carried out through a process of growth and development to the end of fructification in the history of epidemic diseases and plagues, is of itself conclusive against this germ theory of disease; and, if this were not sufficient, another equally fatal objection is the fact that if the germ hypothesis be the true one we would expect that this self-propagating process would go on until each individual affected by it would be utterly eaten up and destroyed; and not only this but also that it would spread from individuals to communities, and that depopulation and extermination would alone stop its progress. This is not, however, the history of epidemic diseases and plagues; on the contrary, both as to individuals and communities, after the disease on the one hand and the epidemic on the other have run their course, with more or less severity and destruction of life,

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they cease of themselves with the causes and susceptibilities of which they are the legitimate product.

I shall now turn to the other hypothesis, or rationale, if you please, which perhaps has a firmer foundation in truth and philosophy, viz., the glandular origin of contagious diseases, and it is possible that in this we shall find the true philosophy of all disease, however communicated. This theory, if not introduced by him, has been warmly and ably advocated by Benjamin W. Richardson, M.D., F.R.S., at the Leamington, England, Sanitary Congress, on two occasions. Of course I do not propose giving, in such a paper as this, a full statement of his views, as that would carry me far beyond the limits assigned to me by the chairman of this bureau, and the purposes that I have in view. I shall content myself with giving some of the prominent ideas presented in them, sufficiently so I trust for the use that I wish to make of them, and for their application to my purpose in their introduction here. This theory—the glandular origin of contagious diseases—is based upon experiments made by its author, through which he "discovered [1] that the fluids secreted during various stages of disease in some forms of communicable disease could be made to propagate disease;" [2] that from these secretions their poisonous matter may be separated, as he had succeeded in doing in one instance, and of which specimens were on exhibition, and that this poisonous matter appeared like an alkaloid, or a chemical substance resembling in physical properties Morphine, Strychnine, etc., derived from animal, rather than like these, from vegetable matter; [3] that this poisonous matter, under favoring conditions, was competent to produce and reproduce poisonous diseases in kind like unto itself. Here of course we recognize the basis of what is ordinarily termed septicæmia. To this poisonous base Dr. Richardson gave the name of septin, and its diseased products he calls septinous diseases.

The next step in this procedure is the conclusion he reached, to use his own words, that "the secretions of the animal body are in fact the sources of the septinous diseases, and that the various septinous diseases are in fact all of glandular origin; that in every case of disease the poison producing it is nothing more and nothing less than a modified form of one or the other secre-

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tion." Also, "that each secretion yields some organic product, the gastric secretion pepsin, the salivary secretion ptyalin, and so on, and each secretion plays a different part in function, although the organic bases of them all may present a general similitude of construction." His observations led him to the conclusion also, to quote from him again, "that the number of the distinctly communicable diseases is closely related with the number of the secretions. The poison of hydrophobia is from the salivary secretion; of diphtheria, from the mucous glands of the throat; of scarlet fever, I believe, from the lymphatic glandular secretion; of glanders, from the mucous secretions of the nasal surfaces; of typhoid, from the mucous glands of the intestinal surface," and so on.

With one more general reference to the views of this learned gentleman I shall have done with the glandular hypothesis, or rationale, whichever it may be, of the origin of contagious diseases, and this relates to the manner, as well as to the fact, of their communication, apart from that of a physical contact. This writer's observations and experimentation have led him to the conviction that the same and similar disturbances and perversions of the glandular secretions may be received through the nervous system by a "nervous impression without the necessary introduction of an infecting particle," as, through fear, anxiety, grief, and other mental states, presenting the same symptomatic phenomena, and not infrequently the same fatal results as those which follow actual contagion, as all of us who have been through a cholera epidemic can abundantly testify. Under this head two other points will close my reference to this branch of my subject and to the suggestions due to Dr. Richardson's able papers. The first is, to quote him again, that "the impression of disease, however induced, is made on a nervous centre, and that contagious diseases, like all which have their root in nervous derangement, present a distinct heredity," are transmitted from parents to children; and, second, that the poison of the venomous snake is the type of all organic poisons, and that men and animals are themselves the producers of the communicable diseases, and when suffering from them are, for the time being, to be regarded as occupying precisely the same position as the cobra or any other

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venomous reptile that naturally secretes a poison, with avoidance and seclusion.

I will here for a moment recur to the fact of the heredity of disease, its transmission from parents to children, from generation to generation, the most profound impression that it is possible for disease to make, in order to notice the fact that this characteristic is common both to those diseases that are recognized as communicable, and to those that are not ordinarily so regarded, thus supplying the link that binds diseases, of whatever name or nature, into a common relationship, if not constituting the keystone of the arch that supports the entire fabric of the pathological status; and, moreover, that this fact also supplies the evidence that disease, from the very outset, is as truly established in the organism as it is transmitted to succeeding generations through the nervous system, by a more or less profound nervous impression. From this it will appear that the glandular theory of the origin of diseases, whether they are communicable or not, is not an essential factor for the maintenance of the theory that I have already indicated, that toxicological and pathogenetic conditions are, equally with those that are termed pathological, dependent upon and due to a nervous impression more or less profound, and which impression must ensue from a contact that is more or less direct. From these premises the conclusion is inevitable that diseases, of whatever name or nature, or however produced, and whether spontaneous or induced, are in the broadest sense of that word contagious.

This brings me back to the resumption of my argument, some of the conclusions of which I have by this digression somewhat anticipated. Returning now to my broad definition of contagion, that whatever will through direct contact produce disease is contagion, I will supplement that definition with the affirmative that the physical contact is not any more a requisite condition for the production or for the dissemination of the recognized communicable diseases than for those that are not ordinarily regarded as such.

This proposition surely furnishes a sufficiently wide scope for both hypothetical and philosophical research, and includes both the toxicological and pathogenetic effects of drugs within the limits

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of such investigations, and recognizes the fact that they are as truly disease-creating and disease-disseminating as are the organic poisons themselves, and this too through a direct, if not always a physical, contact. Without this link in the chain the rationale of homœopathic therapeutics is an impossibility, its Materia Medica a fraud and a mere pretence, and a law of cure unattainable and utterly impracticable. The results of these observations and experience of many years in the application of the law of similia have shown how closely allied, and how firmly bound together, are the phenomena of drug action and of disease action; and that from a common pathological basis are reflected both subjective and objective symptomatic phenomena that testify to a common origin not only, but also that they are the products of a similar, if not of a common cause. Thus alone is it possible that therapeutic agents and pathological states shall sustain the requisite relations, one to the other.

It will be observed that I have placed the organic-septicæmic poisons and the toxicological and pathogenetic effects of drugs on the same footing as alike producers of disease, if not also alike disseminators of it, with the poison of the venomous reptiles as the type of both. Dr. Richardson, as I have shown, has given this prominence to it in relation to what he terms the organic poisons, and our own Materia Medica has perhaps assigned the same relative position for those organic poisons in relation to itself in their pathogenetic and therapeutic use. Thus we find that the venom of reptiles, the poison of the honey-bee, spider, and of others of the animal and insect tribes and races, are common to both the organic and the drug poisons, so-called, and the question may here very properly be raised, if all the vegetable poisons should not be included in the category of organic poisons, inasmuch as they are also the product of organic life. Be this as it may, the poison of reptiles and of insects, which is the product of a normal secretion, and that which results from abnormal conditions in non-poisonous secreting animals and man, are both alike communicable, either through a directly physical or some other mode of contact. That the drugs of our Materia Medica produce their impressions in a similar manner, both their toxicological and pathogenetic effects fully prove, if they do not also

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establish the glandular theory as the correct one as to the origin of diseases that are communicable, as is evinced in the action of Mercury and other similar drugs, and thus warrant the conclusion that all pathological conditions, of whatever name or nature, are the result of a contact of agencies, physical or otherwise, that, under the circumstances of their manifestation, are capable of producing them, and that primarily only through a profound nervous impression.

Having thus reached the common ground occupied by pathology and therapeutics, I may say the straits that connect those two great oceans of thought and investigation, we are prepared briefly to consider some of the causes and conditions that compel their most intimate relationship; and here I find myself almost bewildered and quite perplexed by the variety and prolificness that this theme presents, and especially so in the attempt to keep myself within the prescribed limits of my subject. I shall content myself, however, with but a few suggestions, and perhaps some conclusions, leaving the rest to the more deliberate consideration that its importance demands at your hands.

Premising that as the human organism, whose relations to health and disease we are now considering, is itself the product of the action of forces, and that through the forces of nature it is also developed and maintained through every moment of its existence, it requires no stretch of the imagination, nor illogical inference, to arrive at the conclusion that, in all of our dealings with and in all our speculations concerning it, we must constantly and always revert to and take into account the action and the agency of those forces, and this in all of its diverse and multifarious relations, associations, and conditions. Premising this, we are now ready to revert to the observation that the forces of life, when in equilibrium (not of inertia, for nature knows no such condition), constitute a state of health, also that when this state of equilibrium is in any manner or degree disturbed, to that extent we have a condition of disease, and this, by whatsoever cause induced. We must therefore conclude that the preponderance of the disturbing causes on the one hand, or the predominance of the forces of resistance within the organism itself on the other, becomes the measure of its capabilities as to disease and to health,

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and that the degree of its inherent susceptibilities to disease must determine its capabilities for resistance thereto. Thus is it that contagion is but a relative term, its degree of virulence depending wholly upon the relations existing between the forces of assailment and those of resistance.

Of the fully recognized communicable diseases, the correspondingly mild and malignant nature of vaccinia and of variola represent the degree of assailment, while in the constitutionally susceptible scrofulous subject, and in the perfectly vigorous and healthy one are represented the extremes as to susceptibility. That the same conditions and relations are maintained in the pathogenetic and toxicological effects of drugs, and in the subject of their provings, is abundantly shown in our Materia Medica, as also in the experience and observations of very intelligent physicians in their therapeutic use. It is just at this point that we recognize the key to the improved action of drug force and of the forces of organic life—the interchangeable dynamics of organic and of inorganic life—and this under the homœopathic therapeutic law.

Lest I shall be misunderstood I will repeat right here that in this connection I use the word contagion in its broadest possible sense, as I have already indicated. I think I have shown also that there can be no vital disturbance, and, I may add, no vitality without contact, and that all contact is resolvable into a contact of forces or of modes of force. Life is but a constant succession of contacts and of their resultant changes, and the contagiousness of communicable diseases is but one of its phases, as it is one of its many and varied incidents. Accepting the glandular hypothesis of Dr. Richardson as the most philosophical and rational of any with which I am acquainted as to the origin of contagious diseases, and recognizing the fact that only through a profound nervous impression can they be communicated and transmitted, with or without a physical contact, I cannot avoid the foregoing conclusions, and thus to relegate them with all other forms of disease, and all other phenomena that constitute life to the reciprocal and antagonistic action of the forces of nature. Indeed, in resorting to these minute structures of the animal organism, and to the deterioration of their secre-

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tions as a basis for a rational theory for the origin of contagious diseases, we approach through the glandular system very near to the molecules themselves, and thus very closely to those ultimate forces by which it is controlled, and are brought face to face with the possible fact of a nervous impression as the ultimatum in onr search for the causes of disease. So also through the provings of the homœopathic Materia Medica, whether pathogenetic or clinical, under the therapeutic law of similia, we are brought into close proximity to these same ultimate forces, and especially is this the case where the drugs that compose it are carried into their higher attenuations, and thus into a closer relation to the minute anatomical subdivisions of the organism itself, and of their inherent forces. The inference that is thus implied as to the ultimate cause of all pathological states, however produced, is not as remote or illogical as it may appear to be in the light of the fact that those delicate structures that make the sum of organic life in all its varieties to their remotest limits are each and all capable of recognizing the impressions of heat and light from bodies that are removed millions and billions of miles from themselves, as in the animal kingdom they are also cognizant of those still more subtle and delicate impressions that proceed from mental and emotional function both within and external to themselves, as well as of those that more immediately surround and encompass them. The experiences and the observations of every-day life, in health and in sickness, in our relations to each other, as well as in those that unite us in indissoluble bonds to the lower orders of animal life, as to those of the vegetable kingdom also, through ties of mutual dependence, indicate how surely we are in subjection to the forces of nature through all their modes of expression, however gross or however subtle, and that the rule of dynamic force is both arbitrary and supreme.

From what I have thus presented for your thoughtful consideration in this paper it is not a difficult matter to assign to the subject its proper place and relations. The recognized communicable diseases furnish a typical illustration of the contagiousness of all diseases in the light both of the specific signification of that term, and of its most literal and comprehensive

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one, as also in the light of facts that are familiar to all observing and intelligent physicians; and to the homœopathic physician in the corollaries and conclusions that I have drawn from the premises assumed. I may truthfully affirm that at least a proximate demonstration is furnished that disease as to the fact of its contagiousness is a unit. Scarlet fever is manifestly to be regarded as one of the most malignant, so far as its capabilities are concerned, of the recognized communicable diseases, and is perhaps as much to be dreaded and avoided as any other one of them, inasmuch as its onset is usually so insidious, its course so deceitful and treacherous, and its result so uncertain. The manner of its communication is also so obscure as to render the utmost precaution unreliable; even the strictest seclusion and the avoidance of all intercourse and of physical contact with the subjects of it afford no certain protection against its invasion, as in the case of others of the communicable diseases that are essentially more virulent and more dangerous.

It is scarcely necessary to state that scarlatina is eminently a disease of childhood, almost exclusively so, and the exceptions are so few and so far between where adults are attacked as to be hardly worthy of mention, and this without the protection of a previous attack in childhood or infancy. Nor is it requisite that I shall do more than refer to the fact that a liability to a recurrence of the disease is also reduced to one of exceptional occurrence. There are those individuals, as all experienced physicians have observed, who appear to have an affinity for this disease, and who hold a special relation to it, who are therefore subjected to its repeated attacks. These instances are, however, by no means common, nor are the subjects of this predisposition necessarily exempted thereby from attacks of equal severity, nor do they gain a greater freedom from danger than on previous occasions; in fact security and freedom from danger are terms that have no application to this always dreaded and far too frequently dreadful disease, and as I have before stated, entire seclusion even to isolation affords no sure protection against it.

And here I must leave this subject in your hands, a subject which, in the view that I have taken of it, is full of interest, and one too that reaches out into the domain of scientific inquiry

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and investigation in every possible direction and in every possible way, having no limits but those of the science of life itself, and one also whose study and research will ever supply food for the inquiring mind throughout the remotest generations.

I will only add in conclusion that if the views I have herewith submitted are in any degree novel or strange they are not trivial nor unimportant, nor are they presented on this occasion as final conclusions, but rather as fruitful suggestions that demand at our hands the fullest as well as the most candid and thoughtful consideration, and the most thorough investigation.

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SCARLATINA;

ITS DISSIMILARITY TO DIPHTHERIA AND OTHER CUTANEOUS DISEASES.

By J. P. Mills, M.D., Chicago, Illinois.

Mr. President, Ladies and Gentlemen: Before entering upon our subject proper, we would offer a few thoughts on the general origin of contagious disease. We have looked in vain through the latest and most elaborate works for some expression that should direct the mind from material to dynamic causes for a solution of the vexed question—why?

We find, however, the whole structure of thought built upon the hypothesis,—material causes, and consequently like dosage. Now we need expect little more than this, of a school that has *always* treated the effect of disease as the disease itself, taking a prominent symptom (as constipation), and treating it as the whole ailment, never interrogating as to the disturbing elements culminating in that symptom.

But, alas, we find this same manner of thought rife in our own school. Now for one to hold to the theory of material causes, and at the same time to the cure of disease by infinitesimals, seems to the writer a paradox. In this one respect, at least, the old school is consistent. An allopathist sees in the blood of the diphtheritic, micrococci, and, behold, he has discovered a definite material cause. Now to get those out of there, is the sole indication for him, and the homœopathist tumbles to the idea at once.

Now, what brought micrococci there? We answer, certain chemical changes in the blood. What produced those changes? Altered nerve function. What altered nerve function? Dis-

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turbances of that which makes nerve more than string—vital electricity (the agent of the soul for manifesting and sustaining physical life). But what has disturbed vital electricity? Subtle causes, not material, within its own realm. For all around us in the physical world there is that bearing a similitude to the forces within the body.

Are we to think that this vital principle is hidden away in some undiscovered atom of the brain, impregnable behind its fortifications, affected only by some gross influence upon the body it sustains? No; the electro-vital force spoke life, and the electro-vital force will defend life, and the approach of an enemy into its citadel, be that enemy a physical force or be it not so much as a thought. A breath disturbs at the very first touch, itself. If a sudden thought, an emotion, so far above the material, may produce serious illness, or instant death, then may not imponderable forces from without affect the imponderable within? Like affects like; it disturbs in the one case, it cures in the other. These immeasurable external forces may at one time produce sudden and complete disaster, owing to conditions, and at another an insidious effect, a mere trembling of the life-force, requiring days of incubation.

Whenever the first tilting of the vital fluid from its equilibrium is becoming more and more developed by the accumulation of debris consequent upon imperformance of function, resulting from this first jar from equipoise, until, at last, disease is at its height.

Now it seems to the writer that the most natural place to attack anything is at its maintaining, controlling point. A little made wrong there works great results further on. That there is a vital force, significantly named electro-vital, few will deny. The fact that a needle thrust into a nerve trunk comes out a magnet would seem to set doubt at rest.

Granting this, then, from the very nature of electricity there must be an adjustment of the internal to the external (*i. e.*, of the vital to the natural.) This power of adjustment our bodies have to a greater or less extent, as is obvious, owing to their approximate perfection, at the time adjustment is required. When, for illustration, the atmosphere is laden with what we are pleased

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to call malaria, or other noxious influences, its electrical conditions are manifestly thereby altered, corresponding adjustment is required of our own bodies, failing in this they receive this influence and are themselves thrown out of equilibrium. Hence, we hold that the origin of contagious, and other diseases, is *dynamic*, and that its natural scientific *cure* is *dynamic*, and to be consistent with nature must be governed by *law*. That the totality of the symptoms is but the expression of an electrical condition. Therefore a drug that will cause those same expressions is capable of causing the same electrical conditions. Hence, that drug, given in its essence to correspond with the essence which it seeks to influence, will, according to electrical principles, tropolarize, and a cure is scientifically the result. *Similia similibus curantur.*

Had the subject of this paper been diphtheria, its similarity to scarlet fever, methinks, it would have been a better proposition, for it seems to me that the two diseases now in contrast are growing more and more into each other's likeness. There have been years and times, when the dissimilarity of the two maladies was wide and pronounced. Then again only by the most careful differentiations could a definite conclusion be reached. Let us then, as we study the differences, touch upon those general points common to both. First, then, we find infancy and adult life victims of either malady, as are those, *especially* between the second and twelfth years. Again, the same external causes may produce scarlatina in one, and diphtheria in another. Both are toxæmic diseases, as they are alike fatal. They have their local expression in the same organs, even to a similar eruption upon the skin. We have heard it stated by medical men that infants at the breast were not subject to the infection. We have, however, attended perhaps a dozen cases of scarlet fever in children under nine months of age, some of which were at the breast, while others were fed. Three occurred at the Foundlings' Home, and were sick at the same time, two of them coming down a few days after the first, and while this little epidemic was prevailing, two just as pronounced diphtheritics appeared from the same room. In private practice, too, we have seen scarlatina and diphtheria pre-

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cede and follow each other in the same family, under circumstances significant of a common origin.

Now, as touching the dissimilarity of diphtheria to scarlatina, so much has been said and written that little remains to be said except it be in the line of actual personal experience. Accordingly, we draw briefly from that source, and let the result agree with authorities if it will. Some late and eminent authors hold that diphtheria, contrary to scarlet fever, is first a local disorder, a throat disease, afterwards becoming general. This doctrine we cannot accept. If there is one strong characteristic of the disease under consideration, which is one of the touchstones of differential diagnosis, it is *marked* and continued prostration, often *preceding for two or three days* any local expression. This, then, not only overthrows the local theory, but gives a point of dissimilarity. The onset of diphtheria, generally speaking, is neither so sudden nor so startling. Where it is thus sudden, the case is usually malignant, and easy of diagnosis, and death bids fair to settle any *possible* question, except the physician devotes his time and energy to the unerring remedy. Again, diphtheria is a lower type of disease, has commonly a lower temperature, fatal cases often not registering more than from one to three degrees of fever. Hence, a low temperature does not give the assurance of safety, so long as it lasts, as it does in its kindred disease.

The *breath* of diphtheria is characteristically horrible, yet this same symptom obtains occasionally in scarlatina.

Formerly great stress was laid upon the membrane of diphtheria as a means of positive diagnosis, but recent epidemics have occurred where not a vestige of membrane was present, only in its stead a horrible offensive cheesy substance, easily detached by a gargle of alcohol and water, equal parts; but as this occurs now and then in scarlatina, it only speaks a probability of diphtheria. Again and later, diphtheria has no desquamation, but has, contrary to its relation, vocal paralysis.

Heart failure and heart clot are among the formidable dangers of diphtheria even while the patient is about the house and the danger would seem to be past. Croup is a common complication of the latter as renal trouble is of the former. While these

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general differences exist, that would seem on paper to render diagnosis unmistakable, the practitioner of experience knows that he is often put at his wit's end to name an exact diagnosis as to the one or to the other. Here we must pause and congratulate the profession that they have a system of therapeutics that does not attach the remedy to a hypothetical diagnosis, an error in diagnosis not presupposing an error in therapeutics.

What seems plainly scarlet fever in the first stage seems further on equally plain diphtheria, and *vice versa*. Finally, to make the confusion more confounded, there is a hybrid which is neither one thing nor the other. The points of difference, however, that we would recall are: 1st. The greater premonitory and continued prostration. 2d. The constant aching all over at the outset. 3d. The lower type of fever—lower temperature. 4th. Heart signs and dangers. 5th. Lack of desquamation and renal trouble. 6th. The croupous tendency and vocal paralysis.

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BELLADONNA AND OTHER PROPHYLACTICS IN SCARLATINA,

AND FOR WHAT VARIETIES; INFLUENCE OF SEASONS, CLIMATE, ETC.

By O. P. Baer, M.D., Richmond, Ind.

Fellows of the American Institute of Homœopathy: The Bureau of Clinical Medicine has assigned me the duty of gathering together all the apparently established facts in relation to prophylaxis in scarlatina. The variety to which each medicinal agent corresponds, or, in other words, would produce under certain orderly and predetermined circumstances.

In order to reach the merits of the above requirements let us earnestly inquire what we really mean by the word *prophylaxis.* What idea of its *province* have we in our minds when we use the term? Do we fully and intelligently comprehend that, whatever agent is preventive in any given disease, is also, *a priori, curative* in the same disease? If we do not, then surely we do not appreciate, nor yet comprehend, the sphere of its influence. Worcester, Webster, and Dunglison all agree that a prophylactic is preservative or preventive means used against disease, nothing more, nothing less. This too is the common and accepted definition of the term wherever or whenever used by the most of physicians. Any agent absolutely preventive must be *curative.* If any agent is potent enough in its molecular action to keep off or prevent the inception of animal effluvia, vegetable, mineral, or earthy miasma, it is only exerting the same influence in *driving out* of the human organism what it in other cases prevented from entering; the action is precisely the same,—*prevention, expulsion.* The contagious influence, whatever it may be, enters the life germs,

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or newly formed cells, disturbs their equilibrium, and thus induces disease. The province of a preventive is to forestall this effort by driving off the enemy and setting the captive free. Whether it is at the open door or has just entered the threshold, the force required to prevent impingement must be just as powerful and constant as though the disease had already taken possession. This statement must be true, as no agent can prevent disease whose specific individual medicinal characteristics do not, when given in appreciable or toxical doses, decidedly produce the same or similar symptoms to those expected in the patient from independent or contagious causes. The picture presented as an exact type of the toxical physique of any remedial agent must correspond to the presentations made by the disease, or, in other words, it must be both an image and likeness of the same. Prophylaxis, therefore, properly means any agent which is preventive, preservative, and at the same time curative, of disease. Established prophylaxis is incontestable and conclusive evidence of the law of *similia similibus curantur*.

From the primal *conception* that there was, or ought to be, a *law* of cure to its present development, there has been but one constant and never-ending scene of experimental change, and change of experiments. From the most obnoxious, revolting, and nauseating nostrums used by medical men and the people generally, during the early periods of Christian civilization, through much tribulation and vexation of spirit, we have at last reached an infinitely higher plane of medical practice, where the administration of toxical doses should be regarded as disreputable, and the use of palliatives questionable, in the highest degree.

Formerly everything medical, as well as scientifical, was considered in its complex; now everything must pass through the mental mill of rigid analysis, to the very inmost of all things, even to the severance of cause and effect. By this mode of research the never-to-be-forgotten and indefatigable Hahnemann discovered the hitherto hidden beautiful picture-gallery of symptomatic analogy existing between disease and remedy. In July of 1799 he settled in his own mind one of the most important of medical truths, as he relates in his *Lesser Writings*, page 377, in

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this wise: "*The remedy capable of maintaining the healthy uninfectable by the miasm of scarlatina*, I was so fortunate as to discover. I found also that the same remedy, given at the period when the symptoms indicative of the invasion of the disease occurs, stifles the fever in its very birth, and prevents after sufferings."

"A mother of a large family, during the rage of epidemic scarlet fever of the above date, had got a new counterpane made by a seamstress, who, without the knowledge of the former, had in her small chamber a boy just recovering from scarlet fever. The first-mentioned woman, on receiving it, examined it and smelt it, in order to ascertain whether it might not have a bad smell, that would render it necessary to hang it in the open air; but as she could detect nothing of the sort she laid it beside her on the pillow of the sofa, on which, some hours later, she lay down to take her afternoon's nap. She had, unconsciously, in this way only (for the family had no other near or remote connection with scarlatina patients) imbibed this miasm. A week subsequently she suddenly fell ill of a bad quinsy, with the characteristic shooting pains in the throat, which could only be subdued after four days of threatening symptoms."

He continues the narrative by saying: "Several days thereafter her daughter, ten years of age, infected most probably by the morbific exhalations from the mother, or by the emanations from the counterpane, was attacked in the evening by severe pressive pain in the abdomen, with biting itching on the body and head, and rigor over head and arms, with paralytic stiffness of the joints. She slept very restlessly during the night. With frightful dreams and perspiration all over the body, excepting the head. I found her in the morning with pressive headache, dimness of vision, slimy tongue, some ptyalism, the submaxillary glands hard, swollen, painful to the touch, shooting pain in the throat on swallowing and at other times. She had not the slightest thirst, her pulse was quick and small, breathing hurried and anxious; though she was very pale she felt hot to the touch, yet complained of horripilation over the face and hairy scalp. She sat leaning somewhat forwards, in order to avoid the shooting in the abdomen, which she felt most acutely when stretching or bending back the body. She complained of a paralytic stiffness

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of the limbs, with an air of the most dejected pusillanimity, and shunned all conversation; she felt, she said, as if she could only speak in a whisper. Her look was dull and yet staring, the eyelids inordinately wide open; the face pale and features sunk."

He continues: "Now I know only too well that the ordinary favorite remedies,—as in many other cases so also in scarlatina,—in the most favorable cases leave everything unchanged, and therefore I resolved, in this case of scarlet fever, just in the act of breaking out, not to act as usual in reference to individual symptoms, but if possible (in accordance with my new synthetical principles), to obtain a remedy whose peculiar mode of action was calculated to produce in the healthy body most of the morbid symptoms which I observed *combined* in this disease. My memory and my written collection of the peculiar effects of some medicines furnished me with no remedy so capable of producing a counterpart of the symptoms here presented as Belladonna." Accordingly Belladonna was prescribed, and the disease abated.

I made this long quotation because it was and is the nidus of a great truth, promulged by a great man, full of search and research. This one single case established a primal *factor* in medicine for all time to come.

Acting on Hahnemann's suggestion, when the scarlet fever presented itself in Richmond in 1853, I gave Belladonna, night and morning, to all the children of my patrons, as far as possible, as a preventive, and no doubt saved scores of children where they otherwise would have had the epidemic. It made its appearance about the last of January, and continued more or less violent until April. During that time I treated 126 cases. My success was so marked that even my enemies became my friends in very many instances, and Baer's preventive became very popular, not that I kept the name of the remedy a secret at all (for this conduct among medical men I heartily condemn), but because people asked no questions those days. They were content with whatever the doctor gave them. I went brilliantly through that epidemic with the loss of but one child. I rarely had more than two or three in a family, for as soon as called I inquired how many minors belonged to the household, and gave each child unaffected a dose of Belladonna[30], night and morning,

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and to my great surprise, and greater satisfaction, very few became affected, and those who did were fully impregnated with the disease before they received the preventive.

This epidemic was a pure type of scarlet fever. Most cases were ushered in with a tired, aching, and chilly feeling, followed by heat, thirst, headache, nausea, sore throat. Face and chest soon reddened to a bright scarlet, which rapidly spread over the entire surface. The fever ran very high, and kept up for three or four days with but little abatement. Many were delirious and vomited freely. During this time, and sometimes for several days after, the surface continued red, with very fine petechia, unraised, as the skin was remarkably smooth and shining. Desquamation, particularly of the palms of the hands and soles of the feet, was very general and profuse; have seldom seen it more so. I had but few relapses, and no after-results of a diseased character followed any of my cases. In January, 1860, we were visited by another epidemic of scarlatina of a more or less complicated character. The attacks were often ushered in with vomiting and delirium, severe chill and high fever, scarlet skin, but very rough, and on applying the microscope this roughness was the result of fine, sharp, hard points, very dark red. The mouth became very sore and purple, and the lips often quite dark. This time the disease did not spread, as in the former one, but was more fatal. I treated 56 cases and lost 5. I gave Belladonna freely as a prophylactic. I gave it to 122 cases as a preventive, but inasmuch as several of them were not my patrons, I am unable to say what proportion escaped. I think, however, it was successful, as I saw but 13 or 14 who contracted the disease after its use, and it is probable the great majority of the others escaped also.

In 1864 we had a slight brush of scarlet rash. It was light and did not spread much. I treated it with Apis mel. entirely, and taking it to be a law of cure that similars must cure similars, I gave Apis both as a curative and as a prophylactic. The results were fully as satisfactory as could be desired. My experience with Apis is that where the skin is unevenly scarlet and rough, by being covered with hard, sharp, pointed rash, it is surely as completely curative in this form of the disease as is

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Belladonna where the skin is evenly scarlet all over, smooth, and shining.

In 1868 we passed through another epidemic of scarlatina, more or less malignant and complicated, as many of the more violent cases took upon themselves a diphtheroid form as the period of desquamation was approaching. Here Belladonna did better as a prophylactic than as a remedy during the attack. It required the aid of Lachesis, particularly where the surface took on a purple hue. I feel fully satisfied that where the disease complicates with diphtheria at its incipiency, Lachesis should be the preventive as well as curative. In this epidemic of 1868 I gave 150 children Belladonna as a preventive, and I think less than one-third contracted the disease. Since this epidemic we have been free from the scourge, save isolated cases, a few every season. I have such perfect confidence in prophylactics that I always give them to my patrons adjoining residences where scarlet fever presides.

So little fear have I had of scarlet fever, where I had the privilege of using Bell. as a preventive, that I have never failed to be accompanied by my little daughter to hold my horse while I visited the sick-room, or rooms, as the case might be. I never permit two scarlet fever patients to lie in the same room if possible to do otherwise; sometimes, however, it cannot be avoided, thus increasing the contagious influence. Notwithstanding this, my daughter never took it. As to the use of Ailanthus as a prophylactic in scarlet fever, I cannot speak personally, never having seen an epidemic in which I thought it applicable correspondentially. Dr. George M. Ockford, of Burlington, Vermont, writes me very favorably of it, particularly in cases of an asthenic type, variety scarlatina miliaris. He expresses much confidence in this medicinal agent, although his experience has been slight. I think we are all too slow in peering into the hidden secrets of prophylaxis. There is surely as much pleasure in saving our patrons from disease, as in curing them when attacked. To preserve the *health* by guarding against disease is far preferable to effecting a partial cure, as too often occurs. Last July I was called to attend a bright little German boy, some four years old, with high fever, delirium, vomiting, and

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shuddering as though very cold. Skin looked strangely livid, and was very sensitive to the touch. I gave Aconite 30th, a dose every half hour, and directed the child to be greased with goose grease from head to foot, his feet bathed in hot water, and his head kept cool. I returned in five or six hours to find my child presenting a fully developed case of scarlatina maligna. Skin thoroughly scarlet, hot and smooth, with innumerable flat petechia all over the surface, very fine, and more or less confluent. He continued delirious, with raving, striking, screaming, shaking, trembling, and vomiting, until death relieved him on the sixth day. Aconite, Bell., and Stram. were the remedies used during its different phases, without any relief whatever. The other two children took Bellad. as a preventive; the younger, some two years old, was slightly indisposed for three days, with a very fine faint rash, but played through the whole of it. The oldest child, some seven years of age, broke out beautifully one night without any unpleasant symptoms. Was slightly flighty for one day; went through cleverly; desquamated well, and did well in every respect, owing, I think, entirely to Belladonna as a prophylactic. This rapid onslaught of the disease, which, under more favorable auspices, might have made sad havoc among our city children, was perfectly aborted in its very centre, and not another case occurred within the city, or anywhere near it. True scarlatina can have but one similimum; so with each and every disease there can be but one similimum, but one correspondential image. Why? Simply because there are no two things alike, neither in the heavens, nor yet upon the earth. Now there is a balm for every ill, but we are too ignorant to know it. We are progressing, however. We know a few things, and the time is coming when we will know a great many more. We know even now that Belladonna will cure more cases of scarlatina than any other, or all other agents, known to the whole medical profession.

As to climatical changes and influences, much may be said for and against. Some maintain the disease is not amenable to atmospheric changes, but is purely endemic—that is localized. While others, on the contrary, with a greater show of propriety,

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maintain its epidemic or cosmopolitan character—that is, atmospheric.

In proof of this last assumption I know of no country, or even part of a country, among civilized or savage people, where the scourge has not visited, or is not liable to its visitations. Further, I know of no point where the disease is a constant, or even regular visitor, from any particular influence of locality. In the thirty years that I have been residing in Richmond we have had but five epidemics or general visitations, with occasional sporadic cases intervening. The past winter, while Indianapolis, Cambridge, Eaton, Dayton, Columbus, Oxford, and Hamilton were suffering with the disease, we remained perfectly free. Many other places have suffered seriously this winter—from both diphtheria and scarlatina—while other cities, similarly situated, have remained entirely exempt. Thus it would seem that it obeys neither the law of epidemics nor endemics, but has a law of its own—indifferently cosmopolitan.

Regular temperature has great power in modifying disease, as has been proven this past winter. Diseases have been marked by regular types and no dreadful mortalities. The temperature has rarely changed more than ten degrees in twenty-four hours, for the whole expanse of country between the Rocky and Allegheny mountains. The rainfall has been greater during November, December, January, and February, than for some four or five years past. The sun was clouded fully three-fourths of the time, atmosphere damp, ground chilly yet frozen but little, wind light, generally from the southwest. And notwithstanding these unfavorable presentations our coffin factories in the city of Richmond, who usually ship about one thousand per week, report far less sales during this winter than any winter for two or three years.

Now contrast this state of things with the ravages of disease in the whole of Europe for the same time. The winter, according to statistics, has been one of the coldest for forty years, with the greatest possible amount of sickness and death. Two provinces alone, in the Russian empire, report forty thousand deaths from diphtheria, saying nothing of the mortality of other diseases. According to the reports furnished us in the *Medical*

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Record, the mortality of all the great cities of Europe has strikingly increased during the severity of the weather. Rome reached from thirty-eight to forty thousand per year. In Naples a very malignant fever prevailed. At the health resorts, and near the *Riviera*, cold rains, light snows and damp days have prevailed, causing much sickness. In Berne one hospital received, the week before Christmas, fifty patients suffering from frostbites, all more or less severe. In Paris the applications for entrance into the hospitals during the month of December was *one thousand per week more than the accommodations.* Silesia has been most frightfully ravaged by hunger and typhus, as well as Ireland and Turkey. Very recently a dispatch from Rome to the London *Standard* says: "The accounts from Terra di Lavori continue to be terrible. In seven communes, out of a population of 92,382 persons in the afflicted district, 51,340 had been attacked by fever up to the 15th of December."

Here are sad pictures of continued cold stormy weather, in terrible contrast with our mild, even though wet, weather. One promoting disease of a malignant character, while the other is marked by but comparatively little sickness and death.

Sudden changes from cold to warm, or from warm to cold, are injurious. Even temperature, pure air, dry walls, dry cellars, high stories, milk diet, pure rain-water as a beverage, no stimulants, no animal food, plenty of cod-liver oil, or goose-grease used as a lubricant, to nourish and protect the skin from the ravages of severe desquamation, are all points to be observed in scarlatina; for rest assured if they are sacredly carried out, and obeyed to the letter, the disease will lose half its terror. As to the influence of the seasons I can only speak from my own observation. I have treated patients in all seasons, and at all times. If the weather is continuously severely cold, the disease is decidedly inflammatory in all its phases and aspects, but should the weather be changeable in all its bearings, then you may expect like changes in your patients, such as depressions and exaltations in constant successions. Should the attacks occur in warm weather, or midsummer, with regular hot weather, the disease will be a synochus, though not high enough fever to be called inflammatory in the strict sense of the term. Though

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should the weather be rainy, more or less cloudy day after day, the air light and damp, the fever assumes a synochal type with more or less sequelæ following. Spring and fall—with all the changes incident to them—render the disease uncertain in its course.

Under such circumstances I prepare my own climate. I order a thermometer kept in the room at such a position as will give the proper temperature of the room, say from 65° to 70°. I order the room well ventilated in the morning of each day, thoroughly protecting the patient from the change. I always direct, and see that it is done, to have one window at least down an inch or two from the top. Two patients should never be in the *same bed*, and, *indeed*, never in the same room. A bucket of fresh water by the bedside, and this changed every six hours, is a great absorbent, as well as a great comfort to the breathing of the patient.

Thus I have given you my experience with scarlet fever, its treatment and prophylaxis; its phases and various aspects from weather changes and climate, and hope others will add to my feeble efforts more valuable statistics. Would it not be well for this American Institute of Homœopathy to request every physician in this great commonwealth, to earnestly and faithfully prescribe Bell. as a prophylactic in scarlet fever, and report from year to year to the clinical bureau the results of the treatment. Let our watchword be, onward and upward.

The following letter was received from George B. Peck, M.D., of Providence, R. I.: "Some time since I carefully investigated the ravages of scarlatina in Rhode Island, month by month, from 1859 to 1875 inclusive. My conclusions are: (1), that the disease is endemic; (2), at irregular intervals it bursts forth and rages until every weak defenceless one is devoured; (3), its rapacity is aroused by, and is proportionately dependent upon, great variations in the density of the atmosphere (hence windy or changeable weather), and excess of aqueous vapor therein contained (not necessarily great rainfalls); (4), that the former is the more potent, but is by no means independent of the latter; (5), if both are in excess, or even only one, the other lingering

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near the median point, danger may be apprehended, but if both are low or one only, especially if it be humidity, the other remaining average in degree, comparative safety obtains (relative humidity 71.7, and barometric range 1.175 in., are medium for this State). This principle explains the mysterious phenomena of 'mild epidemics;' the heavier mortality of our (R. I.) winter months, and the extension to older people in so-called 'severe epidemics.'

"Practical lesson: We may not control the elements, but the atmosphere of a sick-room lies measurably within our domain. It is possible in very many cases to keep the air (fresh and) *dry*, then may we regard with comparative serenity every fluctuation of the barometer. If the room or walls be reeking with moisture we may justly be alarmed for the safety of our patients. The use of water under a physician's direction is obviously not contraindicated by this, how, that is a question of treatment. Of the total number of deaths from this cause, 8.81 per cent. were under one year; 14.41 per cent. between one and two years; 40.74 per cent. between two and five years; 26.77 per cent. between five and ten years; 5.98 per cent. between ten and fifteen years. Upon the principle that of two adequate explanations the simpler is the more preferable one, want of exposure is at least an important cause of the lower infantile mortality.

"*Neither* the temperature *nor* the variation of temperature has any influence whatever upon this disease! That was demonstrated so speedily that I threw aside quite early all data collected upon that point, considering further investigation in that direction waste of time."

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SCARLATINA;

TREATMENT OF ITS VARIETIES AND SYMPTOMS.

By Dr. Ad. Lippe, Philadelphia.

Like all other diseases classified under names, and known by that name to the pathologist, the varieties are manifold. The characteristic and predominant symptoms have materially changed during different epidemics at different times and at different places, and the characteristic and predominant symptoms of one epidemic have not even shown themselves in just the same degree and manner in all patients so diseased, in fact, while these characteristic and prominent symptoms were present during the varying epidemics, there were observable on each sick individual prominent and to the individual peculiar symptoms, and these very peculiar symptoms very frequently indicated in this individual case a corresponding and curative remedy. Hahnemann calls our attention to these peculiar symptoms in paragraph 154 of his *Organon.* The observing healer will be governed in his therapeutics by just such peculiar symptoms only, observable on the sick individual, if they are present. In this paper we have only to deal with such groups of symptoms formerly and in succession observed during various epidemics, frequently or generally yielding to remedies corresponding with such groups of symptoms, or with conditions governing one or more symptoms.

The first epidemic of scarlatina observed was in 1840. The most prominent symptoms producing fatal results were, besides the eruption, a very sore, finally ulcerating, throat. The inflammation was very intense, and the pain was described as a burning pain, the intense redness and swelling extended over the whole throat, and found its remedy in many cases in Capsicum.

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Belladonna was rarely indicated, and when given caused no good results. If this inflammation was not speedily cured an ulceration began; the ulcers were generally yellow and soon became putrid. Many cases called for and were cured with Mercurius vivus. Nitric acid very seldom did any good, and only then when the ichorous discharge from the nose with stoppage of the nasal passages appeared, for which condition Lycopodium did at times also good service. Cases which then did not yield to treatment would have probably been cured with Kali bichrom., which was then not proved and not known to us.

Another epidemic was observed in 1859, and in it quite a different group of symptoms appeared. The glandular system was first affected, and the frequently appearing enormous swelling of the parotid gland often ended in the suppuration of it, at the same time the progressive symptoms were a profuse ichorous discharge from the nose and utter impossibility to breathe through it. The swelling and inflammation of the parotid gland, especially when it only affected the right gland, yielded frequently to Ammonium carbonicum, which also corresponded with the later appearing symptoms. When both parotid glands, as well as all the submaxillary glands swelled, Calc. carb. did good service; when suppuration of the parotid gland had set in Silicea was the curative remedy. When in neglected cases the ichorous discharge of the nose prevailed Lycopodium or Nitric acid came into requisition. In this epidemic the great majority of cases were cured by Ammonium carb., not only where I observed the epidemic but also in New York city.

The next great epidemic was observed in 1860, and a very similar one in 1863 in Philadelphia. The two most prominent complications were an intensely sore mouth and throat or diphtheria. The sick complained first of soreness of the mouth, declined to drink on account of the great soreness, very soon the lips became red and swollen, they peeled off, the sick began to pick them, causing them to bleed. This condition yielded readily to very minute and few doses of Arum triphyllum. When diphtheria developed itself the cases assumed a much graver appearance; the sick became very restless, and rolled over the bed in an almost unconscious condition, whining and moaning continually;

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the urinary secretion was suppressed; they declined all nourishment, even drink; the offensive breath increased as the disease progressed. Apis mel. in repeated doses given in solution then became the truly curative remedy; the first indication of its beneficial action was always an increased secretion of urine and a cessation of the tossing about. When diphtheria, as was not unfrequently the case, was also accompanied by a soreness of the lips, when the sick began to pick their fingers and later the lips, causing them to bleed, then again was Arum trif. the proper remedy. Both Apis and Arum had many of the then prevailing symptoms in common. Both cause and cure almost entire suppression of the urinary secretion, both have the same intense restlessness and aversion to drink or eat on account of the pain caused by it in the mouth, both have soreness of the throat, but Arum will invariably deserve the preference when the lips begin to swell, when the sick begin to pick their fingers and lips, and the increased urinary secretion denotes its curative action also. When diphtheria sets in and the incessant desire to clear the throat, to hawk up accumulating secretions, and when these hawked-up secretions consist of tough, stringy mucus, then Kali bichrom. will do excellent service.

During later years the epidemics of scarlatina in the city have become much less severe, less complicated by diphtheria, and we have here now but rare cases of scarlatina, most of them more resembling the old smooth Sydenham scarlet fever, for which Belladonna does excellent service.

When the eruption is suppressed, or will cease to develop itself, we find Apis, Bryonia, Ailanthus, and Sulphur frequently indicated.

Ailanthus becomes indispensable when the eruption assumes a purple hue, when the extremities especially become cold.

Apis mel. will be most useful when at the same time that the eruption, as it were, stands still, we find an entire suppression of the urinary secretion.

Bryonia will be indicated if the patient has been exposed to cold air, and when the breathing becomes painful the lungs becoming implicated.

Sulphur will bring out the eruption when involuntary diarrhoea

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and a comatose condition set in at the very beginning of scarlatina.

After-symptoms *never* appear after careful homœopathic treatment and good nursing, but we are not unfrequently called upon to remedy the evil caused by allopathic or eclectic treatment.

A frequent after-symptom is otalgia. When the right ear is principally affected, and the pain is pulsating or else stinging, Belladonna will often reduce and cure the inflammation. Pulsatilla will affect the left ear more. If a suppurative process sets in Mercurius vivus will be the remedy, especially when the pain is violently darting, comes on in paroxysms, and is worse at night. Has the otalgia not been cured, and suppuration has continued for some time, and otorrhœa has continued, Bovista will be found very beneficial when the discharge is profuse, offensive, and acrid, excoriating the parts with which the discharge comes in contact. In very long-continued cases, especially when new abscesses form from time to time, causing violent paroxysms of pain, German Kino is a very valuable remedy.

Another frequent after-symptom is albuminuria and dropsy. Helleborus is the principal remedy for anasarca; if the genitals principally swell and dropsy sets in, Apis will be the remedy. If we find in the scanty urinary discharges black flakes falling to the bottom of the chamber (decomposed blood) then Lachesis will develop its curative powers.

Many other ever-varying symptoms may arise for which the similar remedy has to be found in our Materia Medica. By necessity we have confined ourselves to state only very prominent symptoms or corresponding remedies; the indications given will be found useful and will be corroborated by such healers as will apply them under a strict adherence to the methods of Hahnemann.

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MY EXPERIENCE IN SCARLATINA.

By S. Lilienthal, M.D., New York.

No greater truth has ever been uttered than that, when Kaposi says: There is no such thing as a light case of scarlatina, as experience teaches that where the virus fails to expend its force on the external skin, it is sure even from the very start to attack the internal skin, *i. e.*, the mucous membrane, and the glandular system. A light case too often gives us those direful sequelæ, whose effects often leave their traces through life. Hence it is the great duty of every physician to disabuse the mind of the public of the distinction so often uttered between scarlatina and scarlet fever; let them know, and let us impress it upon their minds, that the one is impossible without the other; that the high fever, with its rapid pulse, the angina and the eruption are present in every case, and that it is impossible to foretell in any case what the issue may be. The daily examination of the urine, even in most favorable cases, will impress the laity with the idea that there is danger in the air, and it will benefit the physician by detecting at an early stage the attack made by the contagion on the blood-mass, and its sewer, the kidneys.

What is malignant scarlet fever? It may be answered in two words, albuminuria and uræmia, or that peculiar kind of blood-poisoning resulting from the change of urea into the carbonate of ammonia; and carbonate of ammonia, or rather the sesquicarbonate of ammonium ($2NH_46,3CO_2$) has been for ages a favorite prescription in zymotic diseases with physicians of the old school.

My friend, Dr. John C. Morgan, of Philadelphia, acknowledged with great satisfaction that his success in the treatment of this fearful disease arises from the early and steady employment

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of this salt, a drug perfectly homœopathic to the disease, and thus he prevents that very decomposition of the blood which is the cause of the ammoniæmia. Look at the symptoms of the drug, and I doubt whether in our whole Materia Medica there is a drug whose every symptom is so characteristic of this disease. Strong febrile irritation, red diffused spots, with sensation of heat and subsequent desquamation, especially of the trunk, arms, and thighs; inflammatory swelling of tonsils, and of the submaxillary glands; angina, with viscid phlegm to putrid sore-throat and gangrene; feeling of great prostration; catarrhal condition of the kidneys and bladder, with scanty and painful discharge; and the thought must impress itself upon our mind, if generalization could be allowed in our school, that the Sesquicarbonate of ammonium deserves far more to be used as a preventive than the so-much-vaunted Belladonna. The era of pure synochal states has passed, at least in our ever-busy, ever-hurrying country; our patients show their nervous character in health as well as in disease, and we will find, therefore, those so-called nervous remedies more suitable to the times we live in.

After this short digression, allow me to return to my theme, my own personal experience, and if there is any disease which takes the pride out of a fellow, it is this very scarlatina. A few years after I had embraced homœopathy, there raged at Haverstraw, the village on the Hudson I then resided in, an epidemic of scarlatina, and ninety-eight cases I had treated already without losing one. I felt elated, I felt proud, but what a fall,—the ninety-ninth and the one hundredth were fatal cases. It seemed as if my good luck had deserted me, and I had a succession of severe and fatal cases. The quarter of the century during which I have resided in New York has given me many a severe lesson, and allow me to give you some cases from my case-book.

In a family where I attended for years, the father came to me one Sunday morning, requesting my attendance on his daughter, about seven years old, and who was out late the evening before, apparently as well as usual. We have sometimes some premonitions, and I made it my first call. In entering the hall I could smell scarlatina, and in looking at the child my courage failed within me. The child was covered with the eruption, of

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a livid color all over, the eyes stared at me with unnatural brightness, the pulse rushing in a fearful rapidity, and as I predicted, convulsions and coma. I immediately called for consultation. The family were terror-stricken, for they had no idea of danger, as it was only a case of scarlatina, and the rash fully out. Alas! they had no idea that the remaining portion of the contagion, which has no place more on the outer skin, must necessarily throw itself on more important internal organs, and the cerebro-spinal system becomes overwhelmed with it. You may try any treatment or none, such cases are doomed. One physician recommended hot baths and cold affusion, and Belladonna every five minutes; another Cuprum, and if that failed, Hydrocyanic acid; a third one, the Acetate of copper. I never left that child, and it breathed its last after midnight. I have treated two other such cases, with a similar result. Thank heaven that they are the exception.

Equally heart-rending for the physician are those cases which he carried triumphantly through the disease, where only desquamation remains a little tardy and drawn out, but the darling fails to rally, and succumbs to mere exhaustion of life-force. It seems as if the contagium and the out-agonizing and agonizing fever used up all that was of life in the little patient, and he falls asleep to awaken in a better and purer atmosphere. Leave me alone with your brandy or your champagne. We may give them in order to do something, but stimulation is not nutrition, and nutrition fails, because there is no assimilation.

Or during the course of the disease those hard inelastic swellings of the parotes and submaxillary glands have formed, so that deglutition has nigh become impossible, and though desquamation took place, though urination and defecation are as they ought to be, the little patient still languishes, and dies sometimes from exhaustion. Just follow the advice of parents and friends, poultice those swellings to their heart's content, try to pierce it with your lancet; only a few drops of blood follow this uncalled-for incision, for we deal here not with abscess, but with a serous infiltration in the cellular tissue of these glands. The mercurials, so often misapplied in such cases, too often fail, and in those cases where the lime preparations, be it Calcarea ostrearum, or

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Sulphide of calcium, succeed in averting a fatal issue, I think it as much due to their power to rouse assimilation, as to absorb the infiltration. It is astonishing to see how ravenously the appetite becomes as soon as the power of deglutition returns, and it often tasks all our patience to keep fond parents from over-indulging their little one, snatched, as it were, from the very jaws of the grave. How to feed such children is here of more importance than the selection of this or that drug, according to the law of similarity; so, in fact, nourishment, suitable in kind, and as to time, takes now the place of drugs, and the same kind of nourishment will not suit all patients. Here also strict individualization is necessary to reach the goal,—the restoration of undiminished health.

Morbus Brightii also took some of my little patients away. Was I blameless? The case was so light, the rash normal, the fever normal, hardly any angina, the little fellow feeling so well that it was troublesome to keep him in bed, the parents indulgent and the doctor also, and the punishment follows quickly, for our rule must be: "Never to consider any case of scarlatina lightly until many weeks have passed since its first eruption." And how different those cases of Bright's disease are. Yea there is even one form of dropsy which has nothing whatever to do with the kidneys, whose sole cause is loss of vitality, a kind of qualitative anæmia, and for which I have used Apis or Cinchona, and good nourishment with benefit. Kafka led years ago the attention of the profession to Hepar sulphur calc. as a preventive: "We frequently observe, even during the stage of efflorescence, a considerable diminution of the urinary secretion; the urine appears tinged with blood; albumen, fibrinous cylinders and blood-corpuscles may be present in the urine, and still the patient complains of no renal pains, nor does he show any considerable fever." Thus says Kafka, and Kaposi urges daily chemical and microsopical examination of the urine in every case, be it ever so light. Let us follow this advice and our success will be greater. Let us look at the drug, a combination of two great antipsorics, and we will not be astonished at this beneficial action, which is again as much a preventive of the consequent dropsy as its curative drug. In several cases of morbus Brightii Terebinthina has worked well with me, especially where the smoky urine with

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the slow-appearing eruption hinted strongly to threatening uræmia, but also where, after desquamation, the urine showed more blood than casts, the turpentine did its duty. I never yet found out the real indications for Helleborus; it failed in my hands just because I do not know its application, and would feel grateful to be informed about it.

Terebinthina reminds me again of that destructive inflammation of the middle ear, which we have to guard against, and which too often causes incurable deafness. Here again Sulphide of calcium has done me good service, especially in children old enough to express their suffering, and I acknowledge to have given way to the temptation of giving Belladonna during the day, and a dose of Hepar in the evening. We ought to be ever thankful to Cooper to have led our attention to Terebinthina in cases of ear affections during childhood, and the symptoms which he associates for dentition are also applicable to these affections of scarlatina, as suppression of urine, and convulsions, or where the child is wakeful at night, screaming as if frightened, has a staring look, clenches his fingers, twitchings in different parts of the body, picking the nose, cough, etc.

During the many years of my practice I treated successfully some pretty tough cases, and it is a pleasure to look back on them and to know that health was fully restored. I could not tell you what remedy did it, sometimes one and sometimes another; high and low potencies found their applications, for have we not in every case to differentiate between the individuality and idiosyncrasy of the patient, the different stages of a disease and the individuality of the drug? Only a careful consideration of these three factors will enable us to decide in each case what to give and when to employ it.

Post hoc is not *propter hoc*, and still it is a satisfaction to be convinced that in some cases it was *post hoc*, that with the moment when the well-selected drug was given, the Rubicon was passed and amelioration set in. Never mind the *propter hoc*, let us be grateful to mother nature that most cases will tend to recovery, if by over-officiousness we do not thwart the self-sustaining power, which carries us and supports us through life. Let us be servants, and not masters, of this *vis medicatrix naturæ*.

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LATENT MEDICATION.

By P. P. Wells, M.D., Brooklyn, N. Y.

"The original sin is not being able to wait for a thing."—W. Gross.

Whether, indeed, impatience be really the parent of *all* practiced sins in homœopathic prescribing may perhaps be questioned. But it may not be questioned that it is one of the most frequent causes of mistakes and disappointments. It is so natural to be in haste to realize the fruits of our expectations in relief of the pains of our patients and improvement of their state generally, that waiting for these is often more than a weariness; and if these be long delayed, the disposition to do something more, or different, hoping for a better or more speedy result, is often quite irresistible. If we have made our selection of the remedy, already prescribed, with due reference to the requirements of the law of cure which we recognize, this temptation to a too early change of remedy, or to add others to it, in the hope of a better result, should be resisted with the utmost firmness from the beginning. To be *sure* of the right selection of the remedy first given is the one great and first duty of the prescriber, and when he has done this, he should let it alone, that it may accomplish its work without interference, either from anxiety on the part of the prescriber, or the presence of other drugs or appliances which may modify or destroy its legitimate action. To fortify this firmness in the beginning, let him remember this, that for the development of the visible curative action of drugs given to the sick, *time* is required; and further, that different drugs vary greatly in the length of the period necessary for this; with some it is minutes, with others, hours, days, or weeks. Further, that till the lapse of this required period, nothing of good can come

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to the patient by substitution or addition of other drugs to that already given; this being the specific for the case in hand. That it is so we here take for granted. For failing to be this, rules for its administration are useless, indeed they are impossible. For the further strengthening of the timid, let it be borne in mind that as with drugs, so with diseases. These often, before they yield to the curative impression of the drug, must have time before they respond in ease or convalescence. That different forms of disease, and often different manifestations of the same disease, require different periods; some only a brief, others a longer time. And these periods of time, during which we are looking anxiously for visible improvement, often long delayed, are a necessary part of the experience of a cure. And this further and chiefly, that during this period, the drug given, it being the specific, is not necessarily inactive because results of its action are not yet externally visible. This is the period of *latent medication.* It is a necessary part of every true homœopathic cure. The duration of this period is determined by the nature of the morbific cause, and the profoundness of the impression it has made on the organism, on the one hand, and on the other by the susceptibility of the organism to medicinal impression. In cases of croup, for example, relief is often found at the expiration of a few minutes after the dose has been given; in typhoid fever, on the other hand, not till after days. During these days of anxious watching, the action of the drug, although invisible as to any external signs of recovery, is nevertheless potent in effecting the process of cure. The susceptibilities of the organism are so far depressed by the impost of the morbific cause, that they only respond in visible improvement after repeated impress of the curative. These repeated impressions are not fruitless in the process of the cure because traces of their activity are invisible. They are expended, for the time, in recovering the depressed forces from the power of the morbific cause, till they may be able to effect the desired visible manifestations of returning health. The remedy being the true specific, is from the beginning actively operative in bringing about the result it is its mission to accomplish, and therefore the necessity of obedience to the rule which nature and law have established, viz., that it

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be let alone to accomplish this necessary part of the process of cure. It is for no conceivable reason or pretence to be interfered with, by the interposition of other drugs, or resort to whatever of suggestion from our own anxieties or those of others. It being the specific, it is therefore the best possible remedy for the case, and hence to substitute another for it, is to give one which is something less than the best. To interpose another with it, is to endanger the legitimate action of the specific, subjecting it, it may be, either to total destruction, or to such a modification of its true effects as may seriously embarrass the future treatment of the case, and perhaps even to convert a case which is curable, when left to the undisturbed action of its specific, to one which, after this pernicious interference, is wholly beyond the control of the most carefully selected remedy. If the specific be the best remedy, and it fails, then that which is no specific, and therefore not so good, cannot bring us success. It and all others will necessarily fail.

If these views are correct, then it follows that mere delay in the appearance of visible curative effects is not a valid reason for changing the selected remedy in a case under treatment. It may be the best of reasons for revising the choice of our remedy, but never for its change, unless another which is *more like* is found.

This part of latent medication was well seen in a case of typhoid fever which was treated by the writer many years ago. The patient was a young man, twenty years of age, a clerk, of country birth, having been a resident of Brooklyn but a few months. He was first seen and prescribed for on the third day after the attack had confined him to his boarding-house. Previous to this illness he had always been robust, enjoying perfect health. He was found perfectly deaf, in a muttering delirium, talking constantly to himself, not at all noticing his surroundings, or giving the slightest heed to endeavors to arouse him to answer questions. He was in an imaginary world, quietly interested in it, and busy with its images, while he was wholly separated from and lost to all that was real about him. He was sleepless, but quiet, except he made constant efforts to reach and grasp imaginary objects in the air. There was a constant jerking of the tendons of both upper and lower extremities; his

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evacuations were involuntary, the stools were brown, liquid, offensive; the tongue was dry, hard and brown, the lips dry, and the gums covered with dark sordes; skin hot and dry, except at times there was a slight hot perspiration. This was the condition of the patient as early as the third day of the attack. I had never seen so formidable an array of symptoms, developed so early, in any case of this fever. The prognosis was unfavorable. It was the practice of the writer, at this early period of his homœopathic experience, to carry his Materia Medica with him in his daily rounds to the sick, and at the bedside of the patient, after getting his symptoms as clearly and completely as possible, then to study it, that he might find, if possible, the *most like* which cures. He thus visited and studied this case of fever and the Materia Medica twice each day for fourteen days. The first study was a careful and protracted one, and the remedy was selected only after each drug, which in its record carried symptoms similar to those of the case, had been examined. That one was chosen which had most of the symptoms, and these, in its record, the most strongly expressed, that is, that which was *most like*. This was given with the clear conviction that the *best* chance for the life of the patient was in this one drug, and that this was but a poor one. In the evening after the first visit he was no better. Careful study only confirmed the remedy. This was continued for fourteen days, and always the same sad disappointing "no better." It was in the earlier days of the treatment of this case, and after repeated sadness because there was no amendment, and therefore repeated temptations to try some other drug, that this temptation was overcome by the thought that if this remedy, which is *most like*, and therefore the best, fails, what reason is there to hope for better results from that which is *less like*, and therefore not so good? It was this that through that succession of heart-aching studies held the prescriber to the one chosen remedy, though it brought no visible improvement for so many days.

The results justified both the choice of the remedy and the adherence to it through this protracted period of what perhaps cannot be better named than *latent medication*. That there was such a fact was not then recognized. That there *is*, all enlight-

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ened practical experience will now testify. On the fourteenth day the whole train of symptoms cleared away, and in so remarkable a manner as to suggest the passing of a cloud from before the sun. The convalescence was brief and perfect. The whole case was a useful lesson to the attending physician, illustrating and enforcing the value of our fundamental rule for the right administration of our law, the right selection of the remedy, and then adherence to it through whatever of time or discouragement till it ceases to be the one *most like* to the symptoms we are treating.

The disastrous effects of a violation of this rule by a change of remedy, for any other reason than greater similarity, is illustrated by the following case, also of typhoid fever: The patient was a man fifty years of age, of robust frame, who had before his present attack enjoyed general good health. Two or three weeks before he fell sick he buried his wife, to whom he was strongly attached. At the beginning of his illness he told his family he was going to die, and persisted in this as long as he retained his consciousness. He came under my care from that of a friend, whose duties at the time called him from home. It was the tenth day of his illness. He was now in unconscious delirium, talked incessantly of dead bodies or dead persons, coffins, funerals, and matters related to these. He could be aroused to answer questions, but immediately returned to his sad talk and fancies. He had a brown, wasting diarrhœa, which was passed involuntarily, being but slightly offensive. The tympanitis was great; the abdomen sensitive to pressure over the whole extent; the tongue dry, brown, and hard; the mouth dry, and the lips and teeth covered with sordes. The case was carefully studied, and the remedy chosen. Prognosis unfavorable, and chiefly because of the delirium dwelling on death, dead bodies, funerals, etc. Cases of this kind had all died in the previous experience of the writer. Notwithstanding this unpromising state of things the first prescription was followed by improvement in the first twenty-four hours, which continued to progress till the delirium, involuntary discharges, tympanitis, dry tongue, and sordes had disappeared, and the case was promising recovery from all these untoward symptoms, as a break in my uniform experience of fatal termi-

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nation of such cases. There was one fact only which seemed to call for special attention or anxiety,—*he would not take food.* His refusal was constant and positive. The fear of exhaustion from this cause led to a change of medicine, with the hope that this might remove the one, and seemingly the only, impediment to recovery. The expedient failed. He refused food till death relieved him of its necessity. After death it was a matter of regret that the remedy first given, which had already done so much for the patient, had not been trusted for the removal of this one remaining symptom, which was ultimately fatal, notwithstanding the change. It could not be, and cannot be, otherwise than that the question should arise: Was not the death due to this unsuccessful change?

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REPORT

OF THE

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ACUTE GASTRITIS:

CAUSES, SYMPTOMS, AND ANATOMICAL CHARACTERISTICS.

By W. H. Jenney, M.D., Kansas City, Mo.

Etiology.—This disease being an inflammation of the mucous membrane of the stomach may arise: 1. From cold. 2. From undue irritation after a too hearty meal, or indigestible or strongly acid food. 3. From severe medication. 4. From irritant poisoning. The most common of the irritant poisons are ammonia and condensed lye, and, among medicines, croton oil, castor oil, and tartar emetic. Anti-hygienic agencies likewise conduce to the affection, as damp or crowded apartments, in which children are caused to breathe a vitiated atmosphere or noxious gases. Who has not been called to such cases in our crowded cities? A wonder being that the disease is not tenfold more prevalent.

Symptoms.—The most prominent symptoms of acute gastritis may be enumerated as follows: Vomiting of yellow or acid matters; urgent thirst; pale, livid features; sunken eyes; sad or fearful expression, the child complaining if left alone; great sinking of the vital forces, with cooler skin than normal, and, during vomiting, apparently distressing pain, with tenderness at the epigastrium; the bowels, usually, are not distended. The duration of the attack is about one week, but may terminate earlier in collapse. The mouth may or may not be filled with confervoid growths resembling thrush or aphthæ; and this is generally the condition.

Anatomical Characteristics.—The inflammation is most marked at the cardiac orifice, forming small points of ulceration. The inflammation appears to lessen as it approaches the pyloric

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orifice, and is not uniform, healthy membrane being observed between the more intense and less inflamed patches. The stomach too contains a large amount of mucus, the membrane being thickened and softened, and, after death, may be readily peeled away.

Age.—The age at which this affection most frequently occurs is during the first six months, where the child is deprived of its natural nurse and the bottle is substituted, and is rarely seen where the child has a healthy nurse, unless produced by drugs or irritant poisons. I will now relate a case illustrative of the last cause.

Case.—S. H., aged eighteen months; fair complexion; brown eyes; usually healthy. Poisoned by drinking ammonia-water, or water containing spirit of ammonia, designed for washing the head. Immediately after drinking of this solution vomiting set in, followed by acute gastritis. This was controlled by the usual homœopathic remedies, and a milk diet. Several weeks later I was called to the same patient in consequence of a similar poisoning, this time from swallowing condensed lye, and with symptoms much more severe, persisting for several weeks. After the acute effects had subsided a partial convalescence ensued, succeeded by recurrence of subacute attacks, with much vomiting, great prostration and little pain; the only food taken being milk, and very fluid corn-starch made with milk, which may, however, be made without. This condition lasted about one year, with almost restored health. At this period the case was removed from the city, and, under another physician, died from congestion of the brain, probably a reflex condition.

At no time during the continuance of this case was there any sign of stricture in the œsophagus, as one might expect to find from so irritated a case of poisoning.

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ACUTE GASTRITIS OF CHILDREN:

PREVENTION AND TREATMENT.

By W. A. Edmonds, M.D., St. Louis, Mo.

The chairman of this bureau in the exercise of his prerogative, has assigned to me the duty of furnishing a paper on the *prevention* and *treatment* of this disease.

These two branches of the subject are so intimately blended in their relationships, as to make it difficult to treat them separately, the means of prevention and the mode of treatment being so nearly the same in a hygienic and dietitic point of view.

The prevention of disease in any form is synonymous with the avoidance of the cause. Escape the action of the cause in order to prevent the effect or result.

Undoubtedly the great and almost exclusive cause of acute gastritis in young children is dietetic abuse. Of course we exclude cases from poisoning and traumatism. The task of prevention will consist in the proper regulation of the individual's habits as to quantity, quality, and regularity of interval in the matter of diet. It would be hard, indeed, to determine in which of these three particulars our civilized humanity practices the greatest barbarity. As a general rule the higher the grade of the so-called civilization and wealth the greater and more violent the abuse.

A prolific source of gastric disorder to children during the first two years of life is indulgence in solid food, for the mastication of which their few and tender teeth are insufficient. Such food if well masticated would be too strong and hearty for young and tender stomachs, and unsuited even if well masticated and digested for this particular period of life, on account of the gross

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and stimulating character, especially if meat, pastry, and condiments be indulged.

Complication of varied dishes, a source of hurt and peril to the adult, is one of infinite danger to childhood's stomach.

Irregular and insufficient intervals between the time of taking food, cuts an important figure in the ill or well-being of the child's stomach.

The mal-influence of excessive quantity, when of the best quality, is so apparent as to require neither argument nor illustration.

Of course it is not intended to convey the impression that each or all of these forms of abuse combined, always or even very frequently result in well-marked acute gastric inflammation.

But, in nearly every case, not complicated with or secondary to other forms of disease, we shall find simple recent acute gastric inflammation the immediate result of the violent unphysiological use of food. Indeed it would be hard to think of any other probable cause, as children rarely drink spirits, smoke or chew tobacco, use very hot or very cold drinks. The stomach at no time of life is specially and separately under the influence of the malarial epidemic or other toxic agents.

Then if we would save our juvenile clients from the disease under consideration, we should confine them to a milky and farinacious diet, in reasonable quantities and at suitable intervals, until two years old; never allow solid food until the teeth are prepared for the function of mastication; never allow under any circumstances a complication of dishes; no meat oftener than once per day. Children with delicate stomachs should take animal food only in the liquid form.

These objectionable modes of indulgence do not ordinarily produce their results in a sudden, peremptory manner. The patient will not be in normal condition one day and have a violent acute gastritis on the morrow. The process will be gradual and insidious for a time and finally culminate after some special excess in well-established disease.

It is quite the habit with parents, and even physicians, to attribute the trouble to "taking cold," sudden changes of temperature, bad water, and the like. These influences may serve

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as adjuvants, but primarily and alone never cause the disease in question.

A certain class of cases, from some abnormality of the gastric apparatus and function, suffer habitually and protractedly from an acetous fermentation instead of a normal process of chymification, and this too, where we can detect no appreciable departure from good rule as to quantity, quality, simplicity, or regularity of interval. In these cases the gradual erosive action of the acid so impairs the local mucous tissue, in connection with general bodily impairment, as to readily result under slight stomachic excess in the local inflammation. This latter class of cases I presume my good friend Dr. Duncan would class under his head of "acid children;" acid in digestion, urine, stool, perspiration, and temper. Such children are unamiable and unhappy.

TREATMENT.—If the foregoing views as to cause and prevention be correct, our task as to treatment is already largely accomplished. At the outset the child should absolutely trust for subsistence to fresh air and fresh cold water, until such time as the vehemence of symptoms, with which cases usually begin, shall have subsided. Food is both hurtful and useless. It remains in the stomach undigested until ejected by vomiting, giving no support to the system, and by its presence aggravates the phlogosed condition. To meet the demands of the patient and the anxiety of the friends, who will be sure you are about to kill the child with starvation, it may be necessary to practice a sort of dietary *placebo ruse*, by adding a little gum arabic, barley meal, or a few drops of fresh milk to the water allowed as drink. Hot fomentations, in the shape of a flannel 4 to 6 folds thick, wrung every 30 minutes out of hot water, and applied over the epigastrium, with oiled silk or other envelope outside to retain the warmth and moisture, will be found of immense service, by mitigating pain and vomiting, as well as abating the general febrile and constitutional distress.

Our chief medicinal resource will be found in the use of Baptisia, Tartar emetic, Ipecac., Arsenicum, Kreosote, Mercurius.

Baptisia will only be found serviceable in the very onset of

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the symptoms, with fetid breath, furred tongue, much epigastric tenderness and relaxed bowels.

Tartar emetic will be indicated by obstinate vomiting, much abdominal pain, constipation, prostration.

Ipecac. will be called for in the above condition if we substitute relaxation of the bowels for a state of constipation.

Arsenicum will be indicated by great vehemence of symptoms, with a loss of balance in the circulation, as indicated by general prostration, cool surface and extremities, much thirst, feeble pulse and lividity of cutaneous surface.

Kreosote will be found of great service in cases characterized by obstinate uncontrollable nausea and vomiting. No other remedy will be found to meet this particular indication so promptly and uniformly.

Mercury will be called for in cases where there is much bile in the matters vomited, with looseness of the bowels.

Podophyllum may take the place of mercury where there is paucity of bile in the alvine and gastric dejections, with saffron-colored urine.

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STOMATITIS:

PREVENTION AND TREATMENT.

By A. M. Cushing, M.D., Lynn, Massachusetts.

Mr. President and Members of the American Institute of Homœopathy: Although an able pen will relieve us from giving the diagnosis and cause of this disease, if we feel it necessary to refer to some of the causes in order to give the preventive or curative treatment, it must not be considered as advisory or contradictory to the papers offered, even if possibly we may differ from them.

This disease is usually seen in the mouth, in fact is an inflammation of the mouth, yet the seat of the disease is not there, nor is it confined there, as we often see arising apparently from the same cause a disease upon the skin, and objective and subjective symptoms lead us to believe it has a lodgment within the stomach and bowels. Our "old school" ethren give as causes, hot and cold drinks, tobacco, Iodine, Antimony, Arsenic, Mercury, Croton oil, Mezereum, Potassium, Cantharides, Phosphorus, and Phosphoric acid. No doubt these substances will produce the disease, yet we consider the more frequent cause to be debility. It may be congenital or acquired, but the treatment must be directed to both cause and effect. These debilitating causes may be internal or external. It may arise from lack of food in quantity or quality, or it may arise from such external causes as we shall mention later in this paper. Every one must acknowledge it is more frequently seen in debilitated mothers, or children of light skin and lax fibre, and, if no more often seen, it is more protracted and difficult to cure. This being a disease of debility affecting the whole system, appearing generally in the

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mouth, the great danger in treatment is our haste to cure the disease or objective symptoms, sometimes resorting to washes, astringents, etc., driving it from the only open avenue for its escape, and when later the patient dies of hydrocephalus, dysentery, or marasmus, we forget to make the return read, murder in the second degree. If, as our old-school brethren assert, it occurs from the local application of some irritating substance, in such cases we have only to antidote and counteract its effects. When it occurs from improper food, one of our principal objects should be to regulate the diet, and by carefully selected remedies help nature restore the patient. If a congenital trouble, then we need a more careful and extended study and a different remedy. If the child was plump and healthy at birth, and has had rational care, and the disease appears, remedies act speedily and satisfactorily, but if at birth there was a large amount of amniotic liquid, the child had the appearance of being "water-soaked," and the skin has continued soft and loose, we must not expect remedies to act as satisfactorily as in the former case, requiring a longer time and more carefully selected remedies. If we find, as we often do, a child born healthy and without any apparent cause does not thrive well, mouth sore, at times diarrhœa and other troublesome symptoms, we shall find the child has been put to soak, or in other words has been profusely bathed, one or more times each twenty-four hours. Although cleanliness is considered next to godliness, we wish to unreservedly denounce this wholesale abuse of water in bathing children. Standing so nearly alone as we do upon this point there is no room in this paper to try to prove our opinions true, so we will only say the abuse of water produces debility and death many times when we attribute it to something else. For the sake of a starting-point we will assume that the temperature of the entire body of a child is just 98°. Now if an undue portion of that heat is driven to one part of the body there must be a corresponding decrease at the remote parts. In experiments we have made we find that if a child at 98° in the axilla is bathed with water at 112° the temperature is raised to 110°, but in ten minutes the temperature is 94°, a change of both rise and fall of 28° in ten minutes. Now this change cannot be made externally

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without a corresponding change internally. This change may not be equalled internally, but the external decrease of some minutes' duration, to say nothing of the sudden increase, must be *nearly* equalled internally. Such a change oft repeated cannot but be injurious. If the water is used at a temperature below the body there is a reaction above the natural temperature, leaving the internal organs below the normal temperature. If water at 98° is used, if the body is not exposed to the air as is *generally* done, it can have no effect apparently, except cleanliness, and any person of common sense knows that a little child washed clean, dressed in clean clothes, and kept in a clean place for twenty-four hours, does not become so filthy as to need a scrub bath. Then, looking at this matter in a common-sense way, we can see no beneficial results from such a procedure, but a debilitating agent, against which we should carefully but earnestly protest. We cannot deny that we often see children who have been frequently bathed and thrive well, their good health entirely attributed to the bathing. Now that child would thrive well any way with decent care. If so beneficial, why does not the feeble child thrive under such treatment as well as without it? The fact is, it is positively injurious, and none but a healthy child can endure it. Then why not advocate common sense instead of catering to fashion? After doing that, and our duty in regard to diet, we shall have much less to do with medicines than if we follow the routine of folly.

As there is generally more or less derangement of either the stomach, bowels, urinary organs, or skin accompanying this disease, we will give some indications referring to these organs in order to more readily select the appropriate remedy. Before speaking of the positive or proven remedies we will mention one unproven one, Cundurango. We have repeatedly given it in cases of canker, occasionally appearing in the mouth, alternating with dyspeptic symptoms, and these symptoms disappear, followed by an attack of urticaria, after which the patient is well. The cases caused by warm or cold drinks cannot be of a serious nature, but it will be well for us to examine the other substances which our brethren say will produce it. We will not name all

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the remedies that have some symptoms of the disease, but the more prominent ones, as follows:

Æthusa has aphthæ with thirst, increased saliva, at times profuse, with bad taste in mouth. If the child has convulsions the *thumbs will be clenched firmly against the palms of the hands.* Stools green or yellow, watery, *painful.* Urine red, with white sediment.

Aloes has inflamed spots, mostly on the cheeks. Profuse offensive saliva. Diarrhœa worse only in the morning. Small stools with large quantities of flatus; piles; profuse burning urine.

Ammonium carb. has raw inflamed mouth, extending to the throat, with profuse saliva and great thirst, but no appetite. Constipation and burning after stool. Itching of skin, relieved by scratching, but followed by burning.

Antimonium crudum has dry mouth or profuse saliva, tasting saltish, with thirst, changeable appetite, nausea, marasmus, watery diarrhœa, containing little lumps of undigested food; yellow urine (Santonin). Skin sore, either pimples, pustules, boils, or blisters.

Antimonium tart. has very sore mouth, tongue dry and red in centre, worse in the morning. Thirst for cold or acid drinks; drinks little but often (Arsenicum). Stools loose, profuse, painful, green, brown, or yellow, *offensive.* Urine scanty, dark, with a violet sediment.

Arsenicum has aphthæ, or painful blisters; mouth dry, thirst (drinks little at a time), tongue swollen only at the root, coated on edges, dry in middle (Veratrum viride opposite), loss of appetite, green slimy diarrhœa, consisting of mucus. Anus red and sore, worse after stool. Eruption on skin, worse by scratching.

Arum tri. has a red, sore, dry, raw, bleeding mouth.

Baptisia has dry red mouth, offensive saliva, putrid ulceration, fever and *debility.*

Borax has very hot dry mouth, aphthæ, more often on the inner surface of the cheeks. The mucous membrane on the forepart of the palate looks dry and wrinkled, as if burnt. Red blisters on the tongue, painful to touch or from salt. Desire for

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sour drinks. Stools frequent, soft, yellow, slimy, brown, green, light or dark, painless, but *fainting after stool.* Frequent urination, with pain before and burning after passing small quantities.

Bromine has aphthæ, with dry mouth and aversion to water. Painless, odorless, yellow diarrhœa.

Calcarea carb. has slimy mouth, blisters on the tongue and inner surface of the cheeks, variable appetite, and no thirst. Yellow, clay-colored stools; urine dark, but no sediment. The skin is dry or shrivelled, or it is moist and flabby. If the patient, especially a child, has a large head, light hair, blue eyes, inclined to crooked legs, perspiration on the head, the stomatitis will be cured, even if the appearance is unlike that we have observed from the provings.

Cantharis has dry red mouth, with small blisters, at times copious saliva. Thirst, with aversion to liquids. Diarrhœa, with stools white, red or bloody, like scrapings of intestines, burning in anus after stool. Painful urination, with constant desire. Skin sore and burning, followed by blisters.

China has mucous membrane of mouth, sore, but pale, with profuse saliva. Tongue white, more often in the morning, but may be black or raw, as if burned. Debility, with weak feeling at stomach. Symptoms aggravated in foggy weather. Appetite poor. Diarrhœa, with rapid emaciation. Skin yellow, dry, with putrid-smelling ulcers.

Croton oil has redness, rawness, and soreness, but no aphthæ. Appetite good, but sudden desire for stool while eating, so he dare not eat. Diarrhœa, stools watery, green, brown or yellow, coming out with a sudden gush. Skin red and moist, or pustules filled with white creamy pus, very like small-pox pustules, except the indentations.

Colchicum has heat in mouth with profuse saliva, but great dryness of throat. Pale red countenance. No appetite, but great thirst. Stools contain flocculi; green, watery, offensive stools. Urine is copious and light, or dark and scanty.

Helleborus has dry mouth or offensive salivation. Flat yellow ulcers, with elevated gray edges. Ravenous appetite. Loose, white, jelly-like, mucous stools. Urine dark, suppressed.

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Hydrastis has dark-red, sore, raw mucous membrane, with raised papillæ. Great debility.

Iodium has aphthæ, with ulcers, and red, swollen, bleeding gums. Ptyalism. Eats often without benefit; thirsty. White foaming mucous stools always in the morning.

Iris vers. has aphthæ, with great burning, extending to the throat. No appetite nor thirst, yet the mouth and throat burn. Stools profuse and watery.

Lachesis has sore mouth, as more often seen in last stage of consumption. Tongue dry, red, cracked and swollen, protruded with difficulty, as it hits the teeth. No appetite. Thirsty, but disgust for drinks. Stools dark, watery, offensive. Urine dark. Itching of whole body, rash, blisters, or malignant pustules.

Mancinella has burning in mouth, not relieved by water; whole mouth and tongue covered with vesicles and profuse offensive saliva. The dryness extends to the throat, with elongated palate; cannot take solid food, the mouth is so sore. Profuse diarrhœa or bloody stools.

Mercurius has red or more generally white mucous membrane of the mouth, very sore with *profuse, ropy saliva.* Sometimes there are ulcers on the tongue and in the mouth, with swelling of the tongue and glands in the mouth and throat. The gums recede from the teeth, and the teeth are loose. Appetite poor, but more often increased or ravenous, but eats but little. Thirst for *cold drinks.* Stools clay color, green, yellow, or bloody, with *great desire to remain at stool.* Urine may be scanty, flowing slowly or profuse and involuntary. Skin dry, yellow, dirty, sore, itching at night in bed.

Mezereum has burning in mouth with increased saliva and offensive breath. Great hunger at noon or evening, with desire for strong-tasting food like fat ham, and coffee, and wine. Stools soft, brown, sour; *hard balls, but painless.*

Natrum carb. has redness and soreness of the mouth, with flat painful blisters. Increased appetite. Great thirst for cold water, but worse after drinking it. Yellow stools discharged with a gush. Frequent urination of dark sour-smelling urine.

Natrum mur. has dryness and soreness of the mouth with blisters of a dark color; worse from contact with food. Increased

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appetite with desire for salt or bitter food, but aversion to bread or coffee, of which he is usually very fond. Diarrhœa, with dry mouth and thrist, worse from motion. Profuse urine, with thirst for large quantities of water. Rash over the whole body, with itching and stinging.

Natrum sul. has dry sore mouth, with increased saliva and great thirst. Stools slimy or bloody, and suddenly expelled; worse in the morning. Blisters or eczema very moist, with itching while undressing.

Nitric acid has swollen mucous membranes of mouth and gums, receding from the teeth. Bloody offensive saliva. Redness of membrane of the mouth, with ulcers extending to lips, chin, and cheeks, apparently from the acrid saliva. Desire for strong-tasting food. Stools bloody mucus; are green, yellow, or white; worse in the morning. Urine cold when passed.

Nux vomica has only inflamed gums that change to canker sores.

Petroleum has sore mouth, with offensive saliva, worse in the morning, with thirst. Loss of appetite, or increased appetite with aversion to warm cooked food. Thirst for beer, with diarrhœa in the morning and frequent urination. Skin moist, with deep cracks; raw and itching.

Phosphorus has aphthous patches on roof of mouth, with dry mouth, and coated white on mouth and tongue, more adapted to nursing sore-mouth, especially if the breasts are sore. Hungry, but rejects food. Wants cold food more often in night than day time. Stools watery, profuse, painless; better after sleeping. With constipation the stools are small, long, and tough. Urine profuse, with red sediment. Skin red, burning, stinging.

Phosphoric acid has only whitish or gray coating on tongue. Canker may appear after measles. Appetite poor; acid eructations soon after eating. Desires warm food. Involuntary, liquid, gray-yellow stools, which do not debilitate. Urine profuse and light color.

Phytolacca has dry inflamed mouth, with profuse, thick, ropy saliva.

Plumbum has aphthæ, changing to dry dark ulcers, with purple blotches and frothy saliva. Stools light color, watery, or

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hard, lumpy, and *painful.* Urine passed in drops or dribbles away. Skin very sensitive to the open air.

Potassium carb. (Kali carb.) has painful vesicles in the mouth.

Potassium hyd. (Kali hyd.) has irregular ulcers covered with white mucus, looking like milk, with burning in mouth.

Potassium brom. (Kali brom.) has dry mouth with no saliva. During dentition with dry hot gums, an aqueous solution rubbed upon the gums *gives speedy relief.*

Rhus tox. has dry red mouth and tongue, with bloody saliva. Watery stools, with pain extending down the thighs. Urine scanty, hot, dark. Skin red, with small pimples itching violently, burning after scratching.

Sabadilla has dry sore mouth, much worse by either hot or cold drinks. No appetite nor thirst, or increased appetite and great thirst for hot drinks.

Secale has only great debility, and profuse, dark, bloody saliva running from the mouth. Disgust for meat and fatty food. Thirst for lemonade. Stools watery, green, or yellow, offensive, painless. Urine dark, scanty. Cold dry skin.

Stramonium has very dry shining mouth, or raw, with slimy saliva. Stools black, offensive, painful. Urine suppressed or scanty, dribbling away. The whole skin crimson red.

Sulphur has aphthæ or canker sores, with profuse nauseating saliva. Craving for food, but eats but little. Thirsty and drinks much. Brown, watery stools, with retention of urine. Skin bright red, with voluptuous itching.

Sulphuric acid has yellow, painful aphthæ with much saliva. The yellow membrane extends all over the mouth and throat. Loss of appetite and great debility. Worse by drinking water, better by drinking wine or brandy. Yellow offensive stools, with great debility. Urine brown and scanty.

Tabacum has only dry burning mouth and throat.

Thuja has aphthæ and ulcers, with swollen tongue, mouth dry, with desire for cold food or drink, worse at night. The skin looks dark and dirty.

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THRUSH; STOMATITIS PAPULOSUM:

ANATOMICAL CHARACTERISTICS, CAUSES, DIAGNOSIS, AND TREATMENT.

By T. C. Duncan, M.D., Chicago, Ill.

Thrush is a disease which presents a curdy exfoliation on the buccal mucous membrane, and is a disease, or may be only a symptom.

The anatomical peculiarities of this exfoliation distinguishes it from all other diseases. The mouth seems covered in patches with curdled milk, which are difficult to remove. A portion placed in the field of the microscope presents filaments, granules, and epithelium. "These filaments are long cells connected together, between which constrictions are often found. Each cell contains many granules. The ends of the filaments are lost in masses of spores, with a large, often divided, spore cell." (Duncan, *Diseases of Children*, vol. i, page 24.) J. L. Smith is of the opinion that this fungus corresponds to the *Penicillium glaucum.*

Turning now to the mucous membrane we find that it is inflamed, and that the outer epithelial coat is partially denuded; the mouth is hot, dry, and irritated. Such in brief are the anatomical characteristics of this disease.

The *causes* of this disease are of two kinds: (1.) Rapid and increased acidity of the mouth; and (2), rapid and prolonged prostration. The chief cause is wrapping the new-born infant too warm, and covering it too closely, producing a soporous condition from poisoning by carbonic acid gas, retarding secretions in the mouth, and consequently acid degeneration of the mucous

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lining, and at the same time the rapid proliferation and development of the spores of the Oidium albicans.

Thrush is a symptom of two distinct diseases. I refer to athrepsia and entero-colitis. When it is present in either of these diseases it is caused by the prostration and defective nutrition of the buccal epithelial membrane. Here it is a degeneration; while in the other instances its course is inflammatory.

The *diagnosis* of thrush is not difficult. The only disease with which it is confounded is aphthæ. I am sorry to say that many of our works are quite misleading on this point, making thrush and aphthæ as synonyms. In my work I have taken special pains to draw a careful distinction. In aphthæ the follicle is inflamed and looks like a split pea sunk in the tissues, quite different from the appearance of thrush, even in its very incipiency.

In athrepsia the appearance of the mouth will not alone decide the question of diagnosis. The history of the case must help us out. The vomiting, diarrhœa and progressive emaciation precede the appearance of the curdy deposit in the mouth. Here again it is not uniform, but is distributed in patches or islands here and there. All of this leads us to the conclusion that the thrush is not accidental, but significant of serious degeneration of the mucous membrane. It usually makes its appearance during the second stage of athrepsia.

In entero-colitis it stands as a grave symptom near the close of the scene. The long-lasting diarrhœa, the colitis and the fever cannot mislead us in recognizing the true disease. Thrush here does not simply point to the denuded condition of the alimentary tract, from the mouth to the rectum, it means more, and that is that the submucous membrane is undergoing rapid degeneration.

It will be seen that the term thrush being only a symptom of a condition of the mucous membrane, should not be considered a disease. I prefer the term stomatitis papulosum, as being more accurate.

The *treatment* of stomatitis papulosum is hygienic, dietetic and remedial.

A word about preventive treatment. In the new-born this

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disease may be prevented by not covering the child too much; not letting it sleep too long, especially when fed with the first milk; and in giving proper attention to cleansing the mouth, at least once a day, especially if the child is a thin or acid one.

When the disease is fully developed, the child should be given fresh air, and its inflamed mouth should be gently washed out with water. Molasses is recommended for this purpose by Dr. Guernsey. Sage and honey is a popular application. Nothing is so soothing to this inflamed surface as oil. Anything that irritates or turns to acid readily, should be avoided. Cold water is a soothing and excellent article of diet.

The remedy which I have found indicated in this early form of "babies' sore mouth," is *Mercurius*, the 6th trit., a dose once in two to four hours, depending upon the severity of the case. The simple form in my hands has proven very tractable. If neglected this mild inflammation extends deeper. The child cannot nurse or eat from the soreness, and it emaciates rapidly. Here *Mercurius* may not arrest the disease, and *Arsenicum* or *Sulphuric acid, Muriatic acid, Cinnabaris, China,* or some other remedy may be needed.

I do not know of a disease where it is more important to get the totality of the symptoms than in this disease. I depend upon the indicated remedy alone.

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DIET IN INFANTILE DISEASES OF THE DIGESTIVE TRACT.

By Mary A. B. Woods, M.D., Erie, Pa.

No demonstration is needed of the importance of careful and scientific diet in diseases of the digestive tract in infancy, since the principle of nutrition and growth is evidently so powerful, and medicinal action so vague, uncertain, and dangerous in the early periods of childhood. The diseases which, under the head of digestion, we shall consider as particularly influenced by diet in their course and results are: 1st. Those which consist in pathological conditions of the digestive organs proper, such as thrush, gastritis in its different grades, intestinal catarrh, inflammatory and non-inflammatory, and also intestinal worms. 2d. Those constitutional and functional derangements, such as indigestion, mal-assimilation, rachitis, tuberculosis, etc.

These dietetic rules, relating generally to artificial feeding, are to be prefaced by saying that, in most diseases, as usually in health, human milk is of course the best, most natural, and preferable aliment. Either from the breast or from a bottle, human milk should be given whenever practicable, unless it be found to disagree with the child.

In indigestion, thrush, and some other diseases, lime-water should be added to the human milk, to correct the tendency which the excessive accumulation of acid in the passage has to coagulate the casein. Of course the above is considered to be a principle of universal application, and all that follows will relate to artificial feeding.

The various affections given above may be roughly classified, according to the dietetic measures which should be observed in their treatment, into two divisions: The first, consisting of gastritis, intestinal inflammation, enteritis, colitis and worms, which require one plan of procedure in diet; while the second class, as mal-nutrition, rachitis, tuberculosis, etc., are not only to be nour-

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ished, but almost exclusively treated by another and more important system of feeding.

The procedure in diseases of the first or inflammatory class, inasmuch as the diseases are almost always caused by the irritating influence of some undigested and indigestible food, as coagulated casein, or some excess of nutritious matters, the first action should be to remove whatever may be injurious from the diet, and also to interdict all such rich and hardly digested substances. The diet should consist only of unirritating matter, and the aim be not so much to supply highly nutritious as simply mild articles. In gastritis artificially digested aliment may be given by the rectum. Beef tea, milk, etc., are usually not advisable, but very weak and diluted milk, thin oat and barley water are best. But the article I have found most satisfactory in the acute inflammations is a weak infusion of black tea, given cold and in frequently-repeated small doses. This seems less irritating than milk, prepared grains or beef-juice, and equally nutritious, while it subjects the inflamed organs to less labor. If the stomach and bowels be kept free from their functional action, the disease can be limited much quicker than otherwise. As soon as the acute character of the inflammation has subsided in these above-named diseases, the diet given in the second class of cases must be begun.

The procedure proper for the second class of cases is radically different. These diseases arise from an imperfect action of the organs of digestion and absorption, and the dietetic measures for their removal look, first, to supplying in greater quantity those nutritious elements that an imperfect digestive and assimilative function has withheld from the system at large, or from the bones, the lungs, or the blood; and second, to either aid or forestall the weakly performed function of the digestive and absorptive organs; nitrogenous matter may be supplied by Swiss milk, as condensed and for sale, or as prepared by several good formulæ; cows' milk, plus an equal quantity of boiling water, holding one ounce of sugar of milk to the pint, is an excellent means, and the formulæ is accredited to Mr. Turner, a homœopath, by Dr. Routh. Beef juice, either expressed or made into beef tea, infusion of black tea; Ridge's or other methods of prepared flour, one of which is to boil two pounds of the best wheat flour in a bag in water, for

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at least one hour, drying and rubbing the flour through a sieve. Mineral substances may be conveyed into the system by bran tea. To aid or substitute the function of digestion and that of absorption, we have many valuable agents at our command. Liquid and dry Pepsin, given with prepared milk and lime-water, is an excellent nutritive substance. Pepsin, either given separately or mixed with the article of food given, acts no less faithfully and unirritatingly than it has been found to do with adults. The theory has been advanced that, by combining the Pepsin with the nutritive substance outside the stomach, an artificial digestion is produced without the digestive organs playing even a passive part. This seems to me totally erroneous, and I never rely on obtaining digestion without the body. As a convenient means of exhibiting, in one combination, all the essential elements of nutrition so much needed in these diseases, and also to provide for their digestion and absorption, I know of no better article than the Maltin of Messrs. Reed and Carnick, with its various compounds, Pepsin, Pancreatin, and hops. From experience I know this to be far preferable to the many extempore preparations recommended in works on this subject, and I seldom go farther in my search. The Maltin contains the elements of food, and the Pepsin and Pancreatin insure its digestion and absorption, and when diluted in proportion to the age with milk, water, sugar, and a few drops of wine, we have a compound absolutely unexcelled for many cases. The objection to this compound of Maltin with Pepsin and Pancreatin, that it fermented when kept, is obviated by ordering direct from the factory in small quantities. I have done this with the happiest results. The preparation is so entirely practical that I feel greatly like recommending it to the exclusion of further experimentation. The great efficacy and readiness with which the above substances may be obtained allows no excuse for permitting arrowroot and other starchy matters to be given to infants when they are totally unable to digest them.

I cannot close without alluding to the excellent monograph on this subject lately published by Messrs. William Wood & Co., and written by Dr. Routh, of London, and to which I am much indebted.

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REPORT

OF THE

BUREAU OF GENERAL SANITARY SCIENCE, CLIMATOLOGY, AND HYGIENE.

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INTERNATIONAL QUARANTINE.

By Bushrod W. James, A.M., M.D., Philadelphia, Pa.

The efforts that have heretofore been put forth for the establishment of a code of laws between nations on the subject of a uniform system of quarantine, have all looked towards a compulsory enforcement against the inroad of epidemics into the several countries interested in the conference, and so many conflicting interests and measures had to be considered and decided, that nothing sufficiently strong and binding upon all could be adopted or maintained after adoption.

National and commercial interests of different countries clash, and the object intended has always been thwarted. Then again divergent views of sanitarians in different countries exist, in reference to the subject of quarantine, giving very lax laws in one country, and very rigid ones in another, a fact which I had occasion to observe while travelling through European countries some years ago, during the prevalence of Asiatic cholera in the lower part of the continent. In some places travellers were allowed free and easy access, while in other towns, such as were passed through in the lower part of Austria, in Italy and Switzerland, a rigorous disinfection of baggage and persons was maintained.

In our own country we should be able to set an example to the world in this matter; our coast-lines are so extensive, and our seaports are so numerous, our State boundaries and the operation of interstate laws so analogous to those of different countries in Europe, that our nation could make an exemplary set of laws that would operate to advantage between our commonwealths; then all other nations would see the example of the

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same, and eventually one by one adopt them, until an international code would be easy of accomplishment.

Our own national quarantine rules should aim to prevent the outbreak of any epidemic disease within any of our own possessions, and further, in case of such a disaster, they should operate against its being conveyed to other nations—limit the epidemic, whether indigenous or imported, to the locality of its first attack. Let all the government energies in its health, preserving capacities be instantly brought to bear, to crush out any contagious or infectious disease in its incipiency, and never if possible let it assume an extended epidemic form. Let there be organized a force of expert observers, and protected physicians and nurses, and let them be registered and ready at a moment's call during the seasons when epidemics are most likely to occur, and when any case is detected in any city or town let the national quarantine authority assume command for the time, and enforce a "cordon sanitaire," a segregation of affected, a quarantine of the exposed, and a thorough disinfection and sanitation generally over the place, until all cases are well and the danger of a resulting epidemic has fully and entirely passed away, and then, having pursued all necessary measures against its future recurrence, allow local authority to assume its functions. It is the conflict of local claims and interstate authorities with each other that causes many an epidemic to spread and destroy much human life, and millions of dollars worth of commerce. I hold the view that the United States Government, and in fact all nations should prevent any epidemic occurring within their borders, or if originating, to prevent its spread, either among its own people or those of other nations. It is our national duty to do this, and it is the duty of every nation to do it, and once accomplished, and especially if inaugurated in this land, this, our force of example, will extend to other countries, engendering, instead of bitterness, a kindly feeling toward the effort, and those seconding the same, and the wished-for neighborly concert of action in behalf of each other will result and it will redound to the mutual protection and advantage of all that take part in the compact, and throw the *onus* of danger and national ingratitude upon those who do not assent.

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France, in 1838, tried to form a congress of nations possessing Mediterranean ports, with a view to adopting rules that would advantage and protect all that should agree to an "international quarantine" code, but Austria threw obstacles in the way, and it came to nought.

England was in accord with this movement, and in 1843 one of her foreign secretaries, the Earl of Aberdeen, tried to assemble delegates for the same purpose, but Austria again threw difficulties in the way.

In 1851 the French Government invited a conference to meet at Paris for "international quarantine" and sanitary purposes, and besides her own representatives, Great Britain, Austria, Russia, Sardinia, Tuscany, the Papal States, Naples, Turkey, Greece, Spain, and Portugal, all having Mediterranean interests involved, sent delegates.

Five only ratified it and carried out the system adopted for the five years provided by the convention, and then rescinded them, viz., France, Sardinia, Portugal, Tuscany, and Turkey. This code, however, was too binding; it made inflexible rules that upset the laws existing on the subject in some of the countries, and they would not ratify it. If it had alone adopted prophylactic measures for all the countries represented, their home governments would in all probability have sanctioned and enforced them.

In 1859 the French tried another conference at Paris, but the assembly could not agree upon a suitable code that would avoid conflicting interests.

When the Asiatic cholera broke out in 1865, in the ports of Southern Europe and the Levant, its conveyance and spread being attributed to the return of pilgrims from Mecca, France was instrumental in getting together a conference at Constantinople in 1866, the year succeeding the outbreak. In this Egypt, Persia, and all the European states took part, but aside from the scientific consideration of cholera and its prophylaxis, and the subsequent modifications of some of the sanitary regulations of the Southern states present, nothing permanent was effected.

In 1874 another conference was held at Vienna, to adopt measures to prevent the spread of cholera, and to also appoint

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an international commission to study the etiology and prophylaxis of this one disease. This was mainly a medical assemblage, and plausible agreements in reference to international quarantines, pro and con, were adduced, but no plan was adopted.

These efforts all show that the present quarantine regulations of different countries are inadequate, and yet cannot be supplanted. They must, therefore, be supplemented with something better; something nobler, may I urge; something that will take hold of the humanitarian feelings of mankind, and induce them to see the benign effort of protecting their own friends and citizens, and in doing that they necessarily protect all others from these dire calamities. Now our own nation has by special resolution lately sanctioned the call, during the present year, of an international convention to be held at Washington. This is a very important step in the matter of "international quarantine." The Golden Rule should be well considered before it adopts any restrictive measure which all nations represented cannot and will not fully indorse and carry out. Let the United States Government adopt and carry out a magnanimous, self-governing quarantine code, that will protect all its own people first, and then invite other nations to come and see its operation; and if successful, as it should be, let them adopt a similar method themselves at home, and when its security and usefulness are thus proven, let an international code of general rules of action between each other be adopted, and the object aimed at will follow. These rules for our country should extend in their operation to every state and territory, county, township, city, town, and village, so that the railroads and other lines of travel may be quarantined during times of danger, and the interests of the owners of these roads shall also be protected, and shall not be put to unnecessary losses.

If a united, systematic, persistent, international effort was made to annihilate the producing causes of the fatal epidemic diseases that so often sweep countries or large sections of continents, a few years would no doubt suffice to keep them within the region of their origin *de novo*, and a few more years of special research and annihilating effort would eradicate these

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pestilences, and by a rigid continuance of these exertions for generations, the present contagious epidemic diseases can be banished from the earth.

The mode at present in use is incorrect. It is defensive only. The countries now aim to keep these scourges from coming within their borders; while the true plan is to prevent them from leaving any locality where they originate, or are first detected; and national responsibility and penalty should attach likewise to this method, so that procrastination and dangerous delay will not allow any of these diseases to assume the "wild fire," uncontrollable, ravaging force that is at the present day permitted. The task is a great one, but it is not impracticable; and it is as grand, noble, and magnanimous in the effort, as it will be difficult and self-sacrificing to accomplish. For each disease, lifetime service of educated, medical specialists in sanitary science, in the application of the microscope and of chemistry, and in medical science may be a requisite; yet many members of the profession are willing to devote themselves to the great task. The present enlightened age seems a fitting time to begin the work.

Sir Sherston Baker, of London, England, who published a work on *Laws relating to Quarantine*, in 1879, has proposed a very complete set of international rules, which seem to cover the main points required in a code for various nations. They are as follows:

International Rules of Quarantine, proposed by Sir Sherston Baker, Bart., August, 1879.

Article 1. The high contracting parties agree to apply to the plague, yellow fever, and cholera, the sanitary measures hereinafter mentioned. In these articles, the word "disease" shall comprise "the plague," "yellow fever," and "cholera;" the word "infected" shall mean infected by "the plague, yellow fever, and cholera;" the word "centre" shall signify any of the territorial divisions in the schedule* to the articles set out; the

* It is obvious that the "centres" cannot be defined until it is known what states may think fit to become parties to these rules.

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word "consul" shall include "any representative delegated by a consul;" the words "bill of health" shall mean the "international bill of health;" and the word "hospital" shall mean a lazaret or a hospital ship.

ART. 2. At the port of departure, or at any port touched at, every vessel, both before and after she is loaded, may be inspected by the local authority of the port, and by the consul of the "centre" of the port of destination, and she shall be subjected to such reasonable sanitary measures as the local authority may deem necessary. These measures, when necessary, shall be effected at the expense of the local authority, and as quickly as possible, so as to avoid every delay to a vessel.

ART. 3. At the port of departure, the passengers and the crew may be examined by a medical officer, at the request either of the local authority or of the consul of the "centre" of the port of destination. The departure of any person who may be affected by any "disease" may be forcibly prevented by the local authority with or without the request of the consul of the "centre" of the port of destination. Such examinations shall be made as quickly as possible, so as to avoid every delay to a vessel.

ART. 4. There shall only be two bills of health, viz., a clean bill and a foul bill; the first shall state the absence of "diseases" in the "centre" from which it is issued; the second shall state by name the presence of one or more "diseases" in the "centre" from which it is issued. Every bill shall also state the following particulars: the name of the vessel to which it is issued; the name of the captain or master, the tonnage, the cargo, the number and sanitary condition of the passengers and crew, the sanitary condition of the vessel, and the ports at which it is proposed to touch.

ART. 5. Every bill of health shall be drawn up and signed by the local authority of the port of primary departure in the name of the territorial government; and it shall bear the *visá* of the consul of the "centre" of the port of destination, and shall be credited in all the ports of the high contracting parties, subject to the subsequent local and consular *visás*. The consul of the "centre" of the port of destination, may affix a qualified

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or negative *visá* should he think fit; but in such case he shall state the nature of the qualification, or his reason for negativing the signature of the local authority. It shall be optional to other local authorities to admit a vessel with such a qualified or negatived bill of health to pratique, or to require her to undergo a quarantine within the limits set forth in Article 20.

ART. 6. The local authority of every port where a vessel may touch shall require the production of the bill of health of a vessel, and the same authority, and the consul of the "centre" of the port of destination, shall affix their respective *visás* to the said bill of health. Such *visás* may be confirmatory, qualified, or negative, accordingly as the authority or consul may respectively deem expedient; but in the two latter alternatives a reason shall be assigned on the bill of health.

ART. 7. Every vessel shall have one bill of health, and no more.

ART. 8. This bill of health shall be in the following form, and to the following tenor and effect:

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INTERNATIONAL BILL OF HEALTH.

To all to whom these Presents shall come, the undersigned health officer of (name of state), at the port of (name), sendeth greeting.

I hereby certify, that the vessel called the (A.), whose master or (commander) is (B. C.), is about to sail from this port for (X.), in the "centre" of (W.), on——————the——————day of——————18——, and proposes to touch at (D.), and at (E.), on her voyage, under the following conditions:*

Tonnage——————. Nationality——————. Cargo——————. Number of crew——————. Sanitary condition——————. Number of passengers——————. Sanitary condition——————. Sanitary condition of vessel——————.

I further certify, that in this port and neighborhood there is (not) a case of

The Plague.

Yellow Fever.

Cholera.

Dated this——————day of——————, 18——.

G. H.,
Health Officer.

I indorse (or qualify) the above (and say that, etc.)

T. J.,
Consul for W.

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* In the case of a vessel of war erase the words in italics.

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ART. 9. Under normal conditions, when a "centre" is not known to be "infected," the following vessels may be unprovided with bills of health:

1. Fishing vessels.
2. Pilot boats.
3. Revenue cutters and guard vessels.
4. Coasting vessels running between different ports of the same country.

ART. 10. Under normal conditions, by a declaration, to be exchanged between two of the high contracting parties, certain vessels from ports of certain "centres" of the one country going to ports of certain "centres" of the other country may be exempted from the obligation of carrying a bill of health.

ART. 11. No bill of health is to be kept back by any local authority or consul under any pretence whatsoever, except by the local authority of the ultimate port of destination, who shall receive and keep the bill of health.

ART. 12. A bill of health shall only be valid if it shall have been given or *visad* within the forty-eight hours preceding the departure of the vessel, except when the vessel may be detained by stress of weather, provided that in such case she has not communicated with the shore since the date of her bill of health.

ART. 13. Every vessel, from any port which has become "infected" within [seven] days after the departure of the said vessel, shall, notwithstanding a clean bill, be considered to be furnished with a foul bill of health.

ART. 14. A bill of health shall be considered clean although "disease" may exist in the "hospital" of the port of departure or of any port touched at.

ART. 15. Every vessel provided with a clean bill of health which shall not have had whilst at sea any case of disease or any suspicious communication, and which shall present herself in a satisfactory sanitary condition, shall, subject to Art. 13, immediately be admitted to pratique in every port of the high contracting parties.

ART. 16. Whenever a vessel is admitted to pratique, her cargo, passengers and crew (except such as may be "infected"), are exempt from all sanitary measures.

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ART. 17. Every healthy port may protect itself against any "infected" vessel, persons or goods, by placing the same in quarantine, and (subject to Art. 20) by subjecting the same to such sanitary measures as circumstances may render necessary.

ART. 18. The right is reserved to all the high contracting parties to enforce the particular quarantine system of each state, and to make their own municipal rules for carrying out the details of these articles; provided always that no such particular quarantine system or municipal rules shall contradict or render nugatory the present articles.

ART. 19. Whatever the number of sick on board, and whatever the disease or illness, a vessel shall never be sent away from a port without assistance, and due regard being paid to the rights of humanity. But if a port be without a "hospital," the local authority may send the vessel to a neighboring port, or cause the vessel to remain at anchor in an isolated spot under watch of the local authority.

ART. 20. For the more easy application of quarantine, the high contracting parties agree to the principle of a maximum and a minimum quarantine. Every "centre" may adopt either the maximum or the minimum quarantine at pleasure, according to the following scale, which governs all vessels, persons, and goods, except such persons as shall be found on arrival at a port to be suffering from "disease."

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Arrival with bill of health.	Disease.	State of disease.	THE PLAGUE.		YELLOW FEVER.		CHOLERA.	
			Maximum quarantine.	Minimum quarantine.	Maximum quarantine.	Minimum quarantine.	Maximum quarantine.	Minimum quarantine.
Foul.	No case..		Five days.	Three days.	Seven days.*	Five days.*	Three days.	One day.
	Case.....	Recovered.	Ten days.	Five days.	Ten days.†	Seven days.†	Seven days.‡	Seven days.‡
	Case.....	Dead.	Ten days.	Five days.	Ten days.†	Seven days.†	Seven days.‡	Seven days.‡
	Case.....	Subsisting.	Fifteen days.	Ten days.	Fifteen days.	Ten days.	Seven days.	Seven days.
Clean.	No case..							
	Case.....	Recovered.	Ten days.	Five days.	Ten days.†	Seven days.†	Seven days.‡	Seven days.‡
	Case	Dead.	Ten days.	Five days.	Ten days.†	Seven days.†	Seven days.‡	Seven days.‡
	Case.....	Subsisting.	Fifteen days.	Ten days.	Fifteen days.	Ten days.	Seven days.	Seven days.

* If the vessel has been at sea for fourteen days, a medical inspection of the passengers and crew shall be substituted for this period.

† If the recovery or death occurred fourteen days before arrival, this period shall be reduced to five days.

‡ If the recovery or death occurred fourteen days before arrival, this period shall be reduced to four days.

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ART. 21. Every person found to be suffering from "disease" shall, on arrival at a port, be removed to an "hospital," and shall be detained there until recovered.

ART. 22. Every captain or master shall record on the log an exact entry of every communication made at sea, in order to detail it on arrival, if requested to do so by the local authority.

ART. 23. Every vessel on arrival shall be subjected to any inquiry as to her port of departure and destination, and to such interrogatories as the local authority may see fit. She shall produce her bill of health without demand. A ship of war shall only be required to produce her bill of health, but the word of her commander shall be required to guarantee her good sanitary condition.

ART. 24. Should a local authority deem it necessary on the grounds of health, and for a reason to be by them given in writing to the master of any vessel (whatever the bill of health of the same may be), they may cause an inspection to be made of the said vessel before admitting the same to pratique. Should the state of the cargo, or the crowded or infectious condition of such vessel, or any similar cause determine the local authority to detain such vessel for the purpose of considering whether she should be dealt with under the following Art. 25, they are authorized to so detain her for a period not exceeding twenty-four hours.

ART. 25. The bad sanitary condition of any vessel, whether in quarantine or not, shall authorize the local authority to subject the same to such sanitary measures as a vessel with a foul bill of health may be subjected to. If the vessel shall not be placed in quarantine the sanitary measures shall be carried out by the master at his own expense under the direction of the local authority.

ART. 26. The cause for which a vessel is placed in quarantine shall in each case be assigned in writing, and delivered to the master or commander without delay.

ART. 27. Quarantine shall entail such special measures of purification and disinfection, both with regard to vessels, passengers, crew, and cargo, as the local authority may deem necessary. Anything destroyed by fire by the local authority shall be paid for by them.

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ART. 28. The right is reserved to all consuls to be present at the opening and purifying of letters and dispatches which may arrive by vessels, and which are addressed to them or to their countrymen. The same right is reserved to the post-office.

ART. 29. Whenever during a quarantine a case of "disease" shall appear, the quarantine must commence afresh from the date of the death, recovery, or removal from the vessel of the last case of disease.

ART. 30. Quarantine may be performed at an intermediate port between the port of departure and that of destination. On proof being given in writing of such quarantine and of its sufficiency, and attested not only by the local authority of the intermediate port, but also by the consul of the "centre" of the port of destination, such vessel shall be admitted to pratique.

ART. 31. Each of the high contracting parties engages itself to maintain or to furnish for the reception of ships, passengers, crews, and goods subject to quarantine, a sufficient number of "hospitals" for the convenience of travellers and the requirements of commerce.

ART. 32. The interior arrangements of an "hospital" shall be made on the best sanitary principles, and shall be such that the persons and articles in quarantine from different dates may be easily kept apart. There shall be spacious and convenient reception-rooms to enable persons from without to visit those in quarantine without prejudice to the precautions necessary to protect public health. Gratings shall be abolished, as also everything which might have a prejudicial influence on the moral well-being of those in quarantine.

ART. 33. Every hospital must be supplied with good water, and in sufficient quantity. A tariff, fixed by the local authority and publicly exhibited, shall, with the concurrence of the respective consuls of the port, be revised every (six) months. In this tariff the price of food shall be stated at the lowest scale, and such food shall be supplied at convenient hours to the persons in quarantine at their own expense.

ART. 34. A medical officer of the local authority shall, whenever his services are likely to be required, be attached to the "hospital," to visit those in quarantine, and to assist in the exe-

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cution of sanitary measures. His attendance shall be free of charge.

The sick and others detained in hospitals, shall be entitled to such religious ministration and medical comforts as they may require, but the persons employed in administering the same must themselves undergo quarantine. Their services will be paid for by the sick whom they may attend.

ART. 35. The local authority shall, in every case, destroy by fire all wearing apparel or bedding recently used by the dead, or those stricken with any "disease." Other "infected" articles shall be subjected to the most thorough process of purification.

ART. 36. All letters and dispatches shall be forwarded to persons in hospital without delay. Letters and dispatches from persons in hospital shall be purified in such a manner as the local authority may direct, provided that the writing be not obliterated, and shall be forwarded without delay.

ART. 37. The high contracting parties agree not to impose, directly or indirectly, on the shipping, passengers, crew, or goods of the respective states, other quarantine charges than the dues and charges specified in these articles.

ART. 38. The high contracting parties engage themselves to guard rigidly against any "infected" "centres," and to place the same in quarantine.

ART. 39. Articles 2, 3, 9, 21, 24, 25, and 27, respectively, shall not apply to the vessels of war of the high contracting parties.

ART. 40. The present regulations shall be in force and vigor for (five) years. If (six) months before the expiration of that term none of the high contracting parties shall have, by an official declaration, announced an intention of withdrawing from them, the regulations shall remain in force during another (year), and so on from (year to year) until repealed.

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NATIONAL QUARANTINE, INCLUDING SEA-COAST QUARANTINE.

By George M. Ockford, M.D., Burlington, Vermont.

In the consideration of the subject of quarantine the question naturally arises as to the amount of benefit to be acquired from its enforcement. We do know that infectious diseases spread from country to country, from nation to nation, from person to person. That this fact was early recognized may be proven from the history of the Jewish nation. A regular system of quarantine was instituted among that people, as we read concerning the plague of leprosy, that "all the days wherein the plague shall be in him, he shall be defiled; he is unclean; he shall dwell alone, without the camp shall his habitation be." (Lev. xiii, 46.) This was the system adopted over three thousand years ago, and was enforced for centuries. The necessity for isolation and quarantine was acknowledged by many early writers, but we have no reliable accounts of the adoption of a definite quarantine in modern times, until during the fifteenth century. The terrible plague of 1348, which is so vividly described by Boccaccio, and the subsequent emigration of a Turkish population into Europe, with their accompanying filth and disease, aroused the Venetians to proclaim a rigid quarantine. This was variously maintained, having its periods of relaxation and enforcement. Other nations were slow in adopting the system of the Venetians, but we find that the French nation became thoroughly awakened to its necessity when, in 1720, an epidemic of the plague in the Provence carried off upwards of 200,000 of its inhabitants. In this epidemic the city of Marseilles lost 18,000 and the city of Toulon 16,000. Since that time every civilized nation has adopted, and still maintains, some system of quarantine. The origin of the

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issuing of bills of health is involved in some obscurity, Zegata stating that they were issued as early as 1527, while Brownrigg fixes the date at 1668.

Lazarettos, or pest-houses, originated in the south of Europe, and while they facilitated the unloading of cargoes they have proved a source of discomfort and even danger to healthy passengers who have been detained within them. The early systems of quarantine were all national, and their policy one of absolute non-intercourse. The ravages of the plague was the factor that called for the establishment of quarantine. This disease is indigenous to the eastern coasts of the Mediterranean Sea, and in the fifteenth, sixteenth, and seventeenth centuries epidemics were as prevalent in Europe as epidemics of cholera and yellow fever have been in our land in the nineteenth century. In its native country it lingers endemic perennially, and only becomes dangerous when it assumes an epidemic character, and then it spreads wherever its pestilential matter comes in contact. Many medical writers deny its contagious character, but the testimony of eye-witnesses nearly all concur in corroboration of the statement that plague is contagious. Cullen defines it as "eminently contagious," and Dr. Hennen, who investigated the occurrence of the disease in Malta in 1813, says: "It has been among medical men, I am sorry to say, that doubts have principally arisen as to the contagious nature of the plague. This gross and dangerous error, in point of fact, has sprung from the most fruitful source of deception—preconceived theory; . . . and which has exposed us to no small portion of ridicule among the better-informed non-professional men who have interested themselves on the subject." Plague needs for its propagation filth to feed upon, and until we have a system of sanitation that shall effectually rid us of foul spots, our only protection is to maintain a watchful quarantine and shut it out.

The arrival of thousands of emigrants upon our shores, bringing with them the filth and bestiality of neglect of European and Asiatic nations, renders us peculiarly liable to the propagation of epidemic diseases of all kinds. Dr. Van Velsor, city physician of Yankton, Dakota, in 1874, writing of newly-arrived emigrants, says: "A personal inspection of these people will demon-

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strate that they are peculiarly liable to become the porters of disease. In their houses and their habits they are filthy. The use of water is almost unknown among them, and when personally used is, in the majority of instances perverted. A gentleman of Yankton, who was much interested in these people, informs us that on one occasion he observed a female wash her hands, head, feet, and other portions of her person, in a pan of water. Her ablutions having been accomplished, she proceeded to wash a cooking utensil in the same water, and finally, before it was discharged from use, some meat and potatoes, upon which, in a short time, the noonday meal of her family was made. The clothing of these people consists of coarse woollen fabrics; their beds are generally of feathers, and their blankets thick and heavy. The men wear a great coat of the shape and size of an ulster, made of dressed sheepskins, with the wool retained. Their persons are unkempt; their hair and beards long."

The presence of such people among us should make us watchful. In the new condition of our country we have been spared the plague, but as our cities and towns grow older, and the ground and houses become more and more saturated with filth, our danger increases.

All the old cities of England suffered; Canterbury, Oxford, and especially London are examples. The latter city had been devastated and almost depopulated, losing in 1348 nearly 58,000, and every few years from 30,000 to 40,000, until 1665, when the mortality records show 68,596 deaths from the plague. The disease had been introduced from the East, and finding an unsanitary condition remained an almost permanent resident. The great fire of 1666, destroying over 13,000 houses, 98 churches, and public buildings without number, and laying waste 400 streets, destroyed the infection, and rebuilt London gave no resting-place for the plague. The burnt district was rebuilt; the streets were made wider, the houses more roomy, and a system of sanitary regulations inaugurated, which have been improved upon until, with its swarming population of four millions, the rate of mortality compares favorably with the cities of the New World. Between the infected East and our eastern coast, Europe, with its improved sanitation and quarantine, stands guard, but

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our western coast is exposed. The traffic with Asiatic nations, which have no system of sanitary science, no quarantine, and whose aggregation of human beings and filth afford a pabulum for diseases to feed upon, may cause us trouble, and call upon us to maintain a watchful and observing quarantine.

Cholera has attracted the attention of quarantine authorities, and no disease has caused more discussion as to its contagiousness. The opponents of quarantine have all laid great stress upon its inefficiency in preventing the spread of cholera, but all have failed to show that a quarantine conducted according to the dictates of modern science has failed to prevent the disease, while there is abundant testimony tending to demonstrate that a lack of proper quarantine precautions has been responsible for the spreading of the disease from one country to another. Malignant cholera is developed in India only, and it spreads from this focus far and wide. The poisonous virus of cholera is contained in the ejections of a person affected with the disease. This poison may be carried in a dry state in clothing, merchandise, bedding, etc., any distance, and wherever it finds a suitable sanitary condition for its development may cause an epidemic of cholera. The disease always exists in certain portions of India, only occasionally assuming an epidemic form, and then it is a source of danger to the whole world. The various epidemics that have visited our country may all be traced in their wanderings, unopposed by efficient quarantine.

The epidemic of 1832 can be traced from India in 1826–27, Russia in 1829, and England in 1831. Dr. James Hall, R. N., writing in the *Edinburgh Medical and Surgical Journal* (vol. 37, 1832, page 295), gives an account of the appearance of the disease upon some war vessels lying in the river Medway, below London. There was very little sickness on board until "June, 1831, numerous vessels arrived from Riga, where cholera was then raging." Three weeks after this event cholera appeared upon the war vessels, and Dr. Hall gives the testimony that those most violently affected were those nearest to the infected ships. The appearance of cholera at Sunderland in the same year is summed up by Dr. Ogden in the *Medical and Chirurgical Review*, 1832, page 534, wherein he shows that the disease was ac-

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quired through communication between Sunderland and Riga, St. Petersburg and Archangel. It was the custom of the sailors upon arriving in port to have reunions, their chests and clothing were opened indiscriminately, the chests frequently belonging to seamen who had died with cholera. From Sunderland the disease spread through the British Isles, and from thence to Canada, and from Canada we can trace its progress through New York State and to New Orleans. The fact of arrivals of cholera in New York city was suppressed by the Board of Health, and so effectually was it done that no record can be found of quarantine arrivals during the months of April, May, and June, 1832, but that cholera was introduced there is abundance of testimony. For three years after cholera occasionally made its appearance, and there was an immunity from the disease until 1848, when two ships, the New York and Swanton, arrived at our ports. The former arrived at New York city on December 1st, and the latter at New Orleans December 11th. Both vessels had left Havre with German emigrants on board, who had come from infected portions of Germany. There was no cholera at Havre, and the vessels left with clean bills of health, and it was not until one vessel had been out sixteen and the other twenty-seven days that cholera made its appearance. At the time of its occurrence the weather changed suddenly, and a general overhauling of baggage took place in search of suitable clothing, and the captain of the New York testified that on that vessel an emigrant had the effects of an individual who had died of cholera in Germany, and Professor Alonzo Clark in discussing the occurrence says: "It seems to me far more probable that the poison was lurking in the baggage of these passengers, and that the emergencies which required the opening of unventilated trunks and packages let loose in each of these ships that poison brought from the infected regions of Germany." The ship which arrived at New York performed a partial quarantine, but the passengers were soon let loose upon the city. The other ship arrived at New Orleans, met with no quarantine, but immediately discharged her cargo and disembarked the passengers. The latter were lodged in the city, and so thoroughly did they spread the poison that 400 deaths occurred from cholera during the month

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of December, 600 during the month of January, every month showing an increase in the disease until June, when New Orleans lost 2500 of its inhabitants. Can any one doubt that a system of quarantine would have prevented this wholesale slaughter? It is unnecessary to trace this epidemic; 1849 and 1850 are black with the annals of cholera. The importation of cholera caused the epidemic of 1854. In the autumn of 1853 cholera-infected ships arrived in great numbers at the port of New York. In fact it is reported that twenty-eight ships arrived at that port alone in the month of November, in which 1150 deaths had occurred from cholera. The disease broke out in Chicago the following April, and in Detroit in May, the parties attacked being in each instance newly-arrived emigrants. These emigrants had come from infected European ports in infected vessels, carrying about with them in clothing or baggage a poison capable of regenerating itself, and spreading abroad an influence that produced an epidemic in the warm months succeeding. The next epidemic reached the United States in 1865 and 1866. This was traceable to newly-arrived emigrants. The report of Dr. John Swinburne, Health Officer of the Port of New York at the time, says: "From what source did the infection in New York emanate? The answer is simple. Prior to the appearance of cholera in the city all persons exposed to the disease, either on the passage or in this port, were, as I have already stated, detained during a period of twenty-two days, while others, among whom there had been no appearance of cholera during the voyage, but who came from European ports where the disease is known to have prevailed, were mingling with their friends in New York, in the course of from ten to fourteen days from the date of their probable exposure." The disease broke out in various parts of New York city, was communicated to the recruiting station on Governor's Island, and by aid of the movements of recruits was distributed among the United States Army (see report of Assistant-Surgeon J. J. Woodward, U. S. A., Circular No. 5, Surgeon-General's Office, May, 1867). The epidemic of 1866 opened in North America with the arrival at Halifax of the steamer England. Fifty fatal cases of cholera had occurred upon this vessel prior to arrival, and she put into

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Halifax to obtain additional medical aid. The case of this vessel having been so often quoted by the opponents of quarantine to show the barbarities of the system, it may be well to recount the history of the infected ship. She left Liverpool for New York on the 28th of March, 1866, with 1185 German and Irish emigrants, 17 saloon passengers, and a crew of 122 officers and men. On the 1st of April a German boy died of cholera, and when she put into Halifax the surgeon reported 160 cholera cases, with 46 deaths. On the 11th the sick were placed on board the Pyrenees, which had been converted into a hospital ship, and the well landed and placed in tents. The crew and saloon passengers remained on the England. There was no sickness among the latter, and none among the crew after reaching Halifax.

The steamship, having been scraped, scrubbed, and fumigated, left for New York on the 18th, with eight hundred and seventy-five steerage, sixteen saloon passengers, and a crew of one hundred and sixteen officers and men. One saloon passenger died of apoplexy, but the cholera cases were confined to the steerage, where it had thoroughly spread before the vessel performed quarantine. The pilot who spoke the England, the health officer who boarded her, and a number of other persons who had intercourse with the ship, subsequently died of cholera. Three distinct outbreaks of cholera occurred in 1873, in remote sections of the United States, from poison packed in the effects of emigrants arriving from Holland, Sweden, and Russia. These emigrants passed through New York city, one of the best quarantined ports in the world. The failure to arrest it was due to a lack of proper notification.

This partial review of cholera epidemics shows that this disease is introduced into the United States in ships, and that quarantine is of prime importance in preventing it getting a foothold in our land. I am aware that many able men dissent from this importation theory, but until they explain why the so-called malarial influence did not produce cholera in our land during the Mexican war, and during the war of 1861–65, we shall hold firmly to it. In the very region where it is claimed that every epidemic of Asiatic cholera in the United States originated, where

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immense bodies of men were congregated, with all the horrors of bloodshed and suffering, and yet not a single case of epidemic cholera occurred. Even the crowded prison-pens failed to develop cholera.

The question of quarantine in regard to yellow fever has been recently discussed, from the fact that we are all familiar with its epidemic dangers. No disease admits of a greater diversity of opinion, and while we may admit that originally it was an imported disease, we are satisfied that it has become so thoroughly naturalized that it is now indigenous to our soil. This opinion is opposed to that of the Yellow Fever Expert Commission appointed in 1878. It was claimed, in the report of this body, that yellow fever is always an exotic and never an indigenous disease, and further, that "quarantine established with such rigor and precision as to produce absolute non-intercourse will prevent the importation of yellow fever." Thirty-three of the forty-four members of the American Health Association, present at a subsequent meeting, sustained the report, and passed a resolution declaring it to be the duty of the General Government to aid in the establishing of a practicable and proper quarantine by all means in its power. One member of the commission, Dr. Falligant, dissented from the importation theory of the disease, and although the American Health Association had so unanimously agreed to its exotic origin, the executive committee of the society, aided by the advisory committee on legislation, declared that "they were unwilling to formulate any system of quarantine, which might do more harm than good." The commission had an immense amount of work to perform, and but a short time to do it in. The result was that their report was imperfect and manifestly one-sided, and the sober second thought of the members of the Health Association inclined towards Dr. Falligant's views, and at the meeting in Nashville in November, 1879, but a very small majority adhered to the importation theory, and quarantine was not claimed to be more than a useful auxiliary in the prevention of yellow fever. The Yellow Fever Commission appointed by the American Institute of Homœopathy declared that "yellow fever germs always exist in New Orleans and other cities," and stated that in its prevention "quarantine is a delusive security."

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The great work of La Roche on yellow fever shows that the various epidemics that visited Philadelphia prior to 1854 arose from local causes. New York has had an exemption from yellow fever since 1822, only through its improved sanitary condition, and the same statement holds good of Baltimore, Charleston, Mobile, and other cities. Savannah was visited by yellow fever in 1864, when the port was blockaded and communication with the outer world entirely shut off. Seventy-four cases occurred in New Orleans in 1876, and examination by the health authorities "failed to discover the slightest clue to foreign infection from any ship, person, or material." Dr. Joseph Holt, Sanitary Inspector, demonstrates, in the New Orleans *Medical and Surgical Journal* for September and December, 1879, that the forty-one cases occurring in that city during the preceding summer developed spontaneously in five separate and distinct parts of the city, from "air and soil pollution." Yellow fever prevailed at New Orleans when no vessels arrived at the port during the war with England, and Dr. Elisha Harris has conclusively shown that, when the port was thoroughly blockaded, it originated both in the city and among the shipping. Dr. Lebby, Health Officer at Charleston, S. C., writes: "In accepting my present position ten years ago, it was to test this question of importation and local origin. For this reason I have enforced the most rigid quarantine that has ever been enforced in this harbor, and I have satisfied myself that yellow fever can originate within the area termed yellow fever zone, when sanitary precautions are neglected by the municipal authorities."

Pages might be written, all tending to show that yellow fever is indigenous to the shores of the Gulf of Mexico, and that it is thoroughly naturalized in portions of the United States, and that home prevention is the great desideratum. The exotic virus will not propagate unless the condition of the country is such as to produce the naturalized disease. The valley of the Mississippi was devastated by yellow fever in 1878 and 1879, and even the experts who had so strenuously declared the disease to be always exotic acknowledged that not only was New Orleans in a filthy and neglected condition, but that the same was the case in Vicksburg, Memphis, and the other localities visited by the pestilence.

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Do we wonder that the disease raged with such fatality in Memphis? We have only to consider the amount of soil and water pollution to arrive at its cause. The sanitary survey made in 1879–80 discovered that, of the 4744 cisterns and wells which furnish the larger share of the water consumed, 3408 were within contaminating distance of privy vaults known to exist; many of the buildings have groups of such vaults in the cellars, and a general system of lack of ventilation and sewerage prevails. Sanitation is the only remedy for these evils. Quarantine, for the prevention of yellow fever, may keep out the foreign foe, but it is indeed "a delusive security" if we close our eyes to the existence of crying evils at home.

For the general prevention of foreign infectious diseases, systematic and effective quarantine is an important remedy. It should be national. The Constitution of the United States declares it to be the duty of Congress "to provide for the common defence and welfare of the United States," and the prevention of infectious pestilential diseases is certainly a part of the common defence. These diseases are the common enemies of the human race. Why should they be permitted to roam from country to country, slaying thousands? Governments everywhere are leagued together to arrest the course of a murderer, and wherever he turns, he finds every man's hand raised against him. Vagrant pestilences should meet with the same resistance, and a national system of quarantine is the only force adequate to accomplish this result. And in the modern enforcement of a system of quarantine, there is no non-intercourse, shotgun policy. The arbitrary detention of forty days is a thing of the past. Enlightened hygienic requirements do not require the detention of healthy individuals in the close and unhealthy cabins of a vessel. Non-intercourse quarantine has always been attended with much hardship, and its evils more than balance the good derived from it. Sir John Bowring demonstrated to the British Parliament forty years ago, that the strict quarantine of the Mediterranean caused an annual loss of from two to three millions sterling. A quarantine of observation does not obstruct commerce, and permits free intercourse between nations. The principal department of national quarantine is the seacoast or

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maritime. This belongs to the General Government. The Federal authorities alone have power to enforce sanitary regulations on board of ships which are registered and sail under its authority. Experience has shown that vessels are peculiarly liable to carry infection. Unsanitary conditions become intensified in the close unventilated cabins and compartments of ships, and that the infection clings with the utmost tenacity to portions of vessels has been abundantly proved. Yellow fever escaped the effect of cold, heat, and fumigation in the war vessel Plymouth. The same disease developed spontaneously on the steamship Niagara during the year 1879, while on a voyage from Havana to New York. Through its agents, the General Government should be advised of the sailing of these infected ships, and they should not be admitted to *free pratique* until it is settled that the source of infection is removed or destroyed. Quarantine should be established at every port of entry. New York is not only a port of entry for that State, but its arrivals affect the sanitary conditions of the whole country, and so it is with every port in our land. They are ports of entry for the whole United States. Uniform quarantine should be established by the General Government, with only such variations as the exigencies of particular climates or diseases might require. Of what avail is it if a costly defence is erected by one State, while the ports of a sister State are left unguarded? The sanitary precautions of the one may prevent the entrance of imported diseases, while the other, not recognizing the danger, may open its ports without restriction, and allow a focus of infection to enter that may spread pestilence and death throughout the length and breadth of the land. The General Government alone can secure that uniformity of action that will place our seacoast in a position to resist the development of foreign diseases in our land. And while advocating a national system of quarantine, I wish to protest against any such system as shall discriminate against one port over another. Like our customs and revenue regulations, quarantine should be uniform. The commercial prosperity of any seaport in our country might be seriously damaged by a discriminate quarantine, and one of the express commands of the United States Constitution is, that "no preference shall be given to any

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regulation of commerce to the ports of one State over those of another." The means of transit are so rapid between the different sections of the country, that all portions are endangered by the admission of infectious diseases at any port. Sanitary inspection and sanitation should be applied to all vessels arriving from foreign ports. Cargoes and passengers arriving from infected or suspected ports of the world should be subject to proper quarantine regulations. Disinfection and cleanliness should be enforced. The sick should be placed in hospital, and the infected under observation until danger of the disease is past. Disinfection should be applied to the personal effects of passengers, officers, and crews. The collection of reliable information from all parts of the world can only be accomplished by the General Government, and this information would enable its proper authorities to designate what vessels had among its passenger lists individuals from infected ports or parts of the world, and also to which port the vessels were bound. This would enable the quarantine officers to isolate the effects of such individuals for immediate and proper disinfection. Personal effects, clothing, bedding, and hand luggage have been shown to be peculiarly liable to carry infection, and while there should be no restrictions of persons, except for the cleansing of the body and clothing, the other effects should be thoroughly disinfected and ventilated.

Interstate quarantine belongs to the States, and in its enforcement, the national authorities should be an advisory body only. The quarantine of mail matter of course belongs to the General Government, but a system of national quarantine operating between States, would naturally conflict with State laws. If the General Government prevents the entrance of foreign foes, the States themselves should protect their borders from the inroads of indigenous diseases. And in the prevention of diseases which spread from State to State, or by an overland method, quarantine is no doubtful efficacy. The conditions necessary to prevent an endemic disease from becoming epidemic are brought about only by hygienic measures and local sanitation. Sanitary laws have done more to arrest the spread of cholera in India than *cordons sanitaire* and quarantines could accomplish. The cleansing of lodging-houses, drainage, pure air, wholesome food, and the plac-

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ing of all large assemblies of people under sanitary supervision have stamped out cholera from the great fairs where it previously always prevailed.

The expense of a national quarantine establishment, with its buildings and requirements, has been urged as an objection. No objection is made to spending millions for the military defence of our harbors. Millions have been spent upon costly bridges and buildings by the National and State governments, and no word of objection is raised, but when it is proposed to expend a smaller sum in the erection of bulwarks to preserve the public health, then the cost is brought forward as a serious obstacle. No account is taken of the loss of life and derangement of business interests due to an epidemic, which may be prevented. The failure to properly quarantine against infected ships coming from Amoy in 1879, cost the Japanese government over one hundred thousand of its inhabitants. Can any one estimate the money value of lives thus sacrificed? Epidemics cost more than wars, and while we devote millions to the protection of our coasts against the armed foes who may not assault us for a score of years or more, let us not forget that the lives of our people are being threatened by the infectious diseases that constantly linger in the unsanitary portions of the world, and ever be on the alert with a watchful quarantine to prevent their entrance to our shores. The cost of maintaining quarantines along our coasts should be contributed by the whole country. It is a common means of defence, and Ohio and California are as equally interested in preventing infectious diseases from entering our territory through the ports of New York, Boston, or New Orleans, as the States in which these ports are situated. Each is a port of entry for the United States, and when we come to fully realize that "the health of the people is really the foundation on which all their happiness and their power as a state depend," the question of cost will occupy but a small share of the people's thoughts or attention. Its cost would be less than any other department of the government, and every dollar spent would return tenfold in money value, for it is an axiom of finance as well as political economy that public health is public wealth.

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QUARANTINE FOR REFUGEES EXPOSED TO AN EPIDEMIC OF ANY KIND,

BY RIVER, RAILROAD, OR WAGON-WAY.

By D. H. Beckwith, M.D., Cleveland, O.

The yellow fever epidemic which has prevailed in the South for the past two years has caused the subject of inland quarantine to be discussed not only by members of the medical profession, but also by local and state authorities.

If towns and cities distant from the seat of prevailing contagious diseases of a malignant type, were secure from all possible introduction of the same, there would be no fearful visions of the spread of these fatal epidemics.

But such is not the case, for all places are alike liable, during the prevalence of such contagions, to have refugees from infected districts take up their abodes within their limits, who may bring with them the germs of disease that may destroy thousands of human lives. To illustrate what the introduction of a single case of contagious disease may produce, I refer to an instance that occurred in Cincinnati in the year 1849. A steamer left New Orleans while the cholera was raging there bound for Cincinnati. After its arrival at its destination one of the refugees was removed from the steamer and died in a few hours with cholera. From this case the epidemic started, and as a result four thousand one hundred and fourteen deaths occurred in the city from cholera alone, between May 1st and September 1st, 1849.

From the starting-point at Cincinnati it spread to Springfield, Dayton, Columbus, and many other smaller towns and villages; the disease being carried by refugees who fled from the infected city; so that in all, over six thousand people died in the space

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of four mouths. In 1850 the city of Sandusky, situated in Northern Ohio, and then having a population of about eight thousand, suffered more from the ravages of cholera than any other city or town that came under my observation. So fatal was the disease, that during its height the dead could not receive decent burial from the living, and a great pit was dug in the outskirts of the place to receive the remains of the victims of the fearful pestilence. The inhabitants fled by hundreds, even including some of the physicians, who, terror-stricken, deserted their posts of duty. Their places, however, were filled by noble physicians of other cities, who came as messengers of love and mercy to minister to the sick and dying. Dismay, terror, and the pall of death hung over the stricken city, desolate homes and streets were seen in every direction, business was suspended, and all persons that could flee went to county towns, farm-houses, and villages. The cholera followed in the wake of these places to many inland places, where great numbers died, that would otherwise have escaped had the railroads, rivers, and wagon-ways been properly quarantined.

The sad havoc that yellow fever made in the South is fresh in the memories of us all, and the want of proper quarantine precautions, as is well known, allowed the disease to spread to many cities, which but for these omissions would have remained entirely exempt from the pestilence. "The greatest good to the greatest number" is an old and true saying, and one that demands the institution of rigid inland quarantine during periods of contagious epidemic diseases, and one that also justifies the creation of such barriers. The objections are that they separate friends and families, prohibit social intercourse, destroy trade and commerce, and cripple and perhaps bankrupt many prosperous business houses.

We are now led to inquire what means can be adopted in the future, so that epidemic diseases may be confined to the infected locality, and those persons escape therefrom that may so desire, without jeopardizing the lives of others. How can we transport and care for refugees that leave by river, railroad, or wagon-ways?

No state or local authorities can reach the different parts of the country in time to prevent the spread of disease by refugees.

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The General Government alone is the only potent power that can give instant aid and protection against such dangers. We should have such laws and regulations enacted at Washington as will give its officers authority to act in every state and city in the Union. Local and state authorities should be consulted, but the government officials should be armed with such powers as to cause the state authorities to yield and submit to their decrees.

These quarantine officers should be men of firmness, and well informed in sanitary science and all subjects pertaining thereto. They should have power to take for the use of refugees, both railroad cars, steamers, and other means of conveyance, the same to be employed for the best interests of persons fleeing from infected cities, under their direction and supervision. The government to decide the compensation to be paid owners of property, when the same has been thus appropriated for the public use.

The government should also select, through its officers, a suitable location, healthy and easy of access and egress, and establish thereon such buildings as may be necessary, and also provide good rules for sanitary regulations.

Refugees leaving an infected district should proceed by the conveyances provided for them, to the government refuge, where, upon their arrival, they should be stripped of their clothing and a hot bath given them, after which they should be sponged over thoroughly with alcohol, and then provided with clean clothing. The ground that they pass over in coming from the boats or cars should be sprinkled with sulphur, pulverized charcoal, or other disinfectants.

After leaving the bath-house they should proceed to a hospital hotel, situated some distance from the bath-house, where they should remain from ten to fourteen days, being provided with good food and well-ventilated rooms.

Persons who have had yellow fever, and can so satisfy the officers by a certificate from the attending physician, or otherwise, should be permitted to resume their travels after they have passed through the bath-house and have been provided with new clothing.

If the contagious disease should break out in the hotel, the patients should immediately be removed to the hospital provided

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for them upon the appearance of the first symptoms of disease. The hospital should be several hundred feet distant from the hotel.

A moist damp atmosphere of several days' continuance may develop some hidden germs while the refugees are in hotel quarantine. To keep the air pure, and to prevent the appearance of poisonous germs, ozone should be used in all the apartments of the hotel, as well as in the hospital.*

Cars, boats, or wagons, that have conveyed refugees, should be thoroughly fumigated with sulphur or other disinfectants as soon as unloaded.

Clothing that has been removed from refugees should be immediately destroyed. Valuable papers that may be in their possession should be heated in an oven to a temperature of 212° Fahr., so as to destroy any germ that may be lodged among them.

In the hotel, hospital, and all buildings that may be in use on the quarantine grounds, earth-closets should be employed. They should be prepared with the greatest care, for, as Dr. Simon says, "Of all the filth-influence which prevails against human life, privies of the accumulative kind operate undoubtedly to far the largest extent." The dry-earth closet is well known for its antiseptic and purifying properties. The earth should be thoroughly dried and contain no vegetable substance. A cubic foot of earth should be allowed to a closet that accommodates five persons; it taking about ten pounds of earth to deodorize the excreta of one person.

The closet known as the "Rochdale Closet" is an excellent one. It consists of a barrel holding from one hundred and fifty to two hundred pounds, and in which dry ashes are used in the same manner as the earth. The barrel should be removed every twenty-four hours, and well fumigated before it is returned.

General sanitary rules and laws should be observed in all buildings connected with the quarantine grounds.

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* For the past four years I have used ozone in cases of malignant diphtheria, scarlet and typhoid fevers, and am satisfied that it has great disinfectant properties.

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The old and rigid rules of ancient times are not applicable to the intelligence and knowledge which this nation now possesses.

Medical science has made great improvements in the past fifty years in the treatment of diseases. Sanitary science within the past ten years has become better understood by the medical profession. I believe that in a few years diseases will be so well understood and so much under the control of medicine and its accessories, that cholera and yellow fever will be robbed of half their terrors, and that but comparatively few deaths will occur from any known epidemic that visits us.

The older members of the Institute can certify that the death-rates of cholera patients treated by homœopathic medications are comparatively small.

Yellow fever, that prevailed in 1878 and 1879 in the South, was, as we all know, of a malignant type. The mortality, according to statistics under old-school medication, was from thirty to fifty per cent., while the physicians of the new school report only from five to ten per cent.

With so small a mortality under homœopathic medication, and the institution of good sanitary rules and regulations, these dread diseases will soon lose half their terrors.

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DISINFECTION OF PEOPLE, CARGO, AND BAGGAGE IN QUARANTINE.

By M. S. Briry, M.D., Bath, Me.

Without making any preliminary remarks on the subject assigned to me, I will state, in as short and concise a manner as possible, the information coming to my knowledge.

Disinfection is purification, and here purification from disease and its products, rendering them innocuous.

If, at the commencement, we confess to our limited knowledge of disinfectants which are really efficacious and practical, there will not be any disappointment at the close.

Has an all-wise and omnipotent Creator placed his creatures under such circumstances and environments as to lead to the immediate impairment of their functions and destruction of their organization without putting the means of preservation within their reach and control?

When the organic world, vegetable as well as animal, is examined, it will be found to be subject to disease and decomposition, as well as vitality and growth, and, farther, that the dissolution of some parts is necessary to the vitality and growth of others. The excreta, exhalations, effluvia of animal bodies, whether in a state of health, disease, or decay, only become a source of disease when accumulated in too large a quantity or in too close proximity to other animals.

God so wisely created the earth and all that appertains thereto, that life, both animal and vegetable, is sustained, prolonged, matured, and so wisely arranged that matter inimical to animal life contributes sustenance to vegetable life.

Before speaking of any special disinfectants, those powerful disinfectants provided by nature should be mentioned. The

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surface of the earth presents one broad field of unlimited disinfecting powers; and if the large towns and cities, instead of expending so great sums in constructing sewers to discharge their contents into the rivers, thus poisoning the water, and in time converting the shores into a source of pestilence, would devise ways to carry all the excreta from water-closets and privies, together with contents of stables and all garbage, into the surrounding country, where they might be utilized by enriching the cultivated fields, increasing their productiveness, becoming a revenue instead of a nuisance, they would manifest their wisdom, reduce their rate of taxation, obviating the necessity of disinfectants or reducing it to a minimum.

The earth acts as a disinfectant, not only as an absorbent and deodorizing agent, but also by converting the disease-producing material into plant food.

The atmosphere is another natural disinfectant, acting in a twofold manner upon the products of disease and disease-producing material. First, attenuating the emanations so far that they are no longer infectious. Second, by oxygenating them.

It is quite well established that heat will destroy the virus of small-pox; a low degree of temperature the contagious emanations of yellow fever; a free circulation of pure air dissipates those of scarlatina and typhus.

Given time and space, little more than the agents named would be required as disinfectants in quarantine or elsewhere.

In the turmoil and haste of active business life there is something demanded to expedite the forces of nature, to cut short even the delay of time.

When the many substances known as disinfectants are examined, it will be found, either from their deleterious effects upon persons and textile fabrics or their expense, only a few can be utilized in quarantine.

For the disinfection of people, free, thorough ablution in pure water, using about the hair carbolized soap, will prove to be as efficacious as any, the most convenient to apply, and economical in use. In some diseases, as cholera, it will be necessary to subject all the excreta to the action of some disinfectant, such as carbolic acid, sulphate of iron, chloride of zinc, or manganese.

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Baggage, consisting of the wearing apparel of individuals diseased, or from an infectious district, should be subjected to a rigid process of cleansing where the material will admit of washing, and rinsing in weak solution of carbolic acid, sulphate of iron, chloride of zinc, chloride of lime, soda, potash.

Those materials which will not admit of washing should be subjected to aerial disinfection, so-called, that is, suspended in an atmosphere containing sulphurous acid, chlorine or dioxide of nitrogen. And here ozone may become a more important disinfectant than any other known.

The Homœopathic Yellow Fever Commission, in their able report, among other means to prevent the development of yellow fever, recommend the generation of ozone, saying: "It is so powerful as a disinfectant that one part of it will purify three million parts of atmospheric air. Ozone is thus nature's great disinfector and purifier, more subtle, powerful, and ubiquitous than all others, and we must learn to utilize this splendid gift of the Creator for our own sanitary blessing."

It would seem that here is an agent capable of accomplishing great and general results as a disinfectant; but many experiments, conducted in a scientific manner, will be necessary to understand and utilize it.

It is not yet proved that ozone, generated in an artificial manner, is identical with the ozone existing naturally in the atmosphere, but it matters not whether ozone produced by slowly oxidizing phosphorus, turpentine, from peroxide of manganese and other salts, by electrolysis, is identical or similar, should it prove to be a powerful, efficacious, safe, convenient, and easily applied disinfectant.

If ozone fulfils the predictions and expectations of scientific men, a whole ship, passengers, baggage, and cargo, may be disinfected in a few hours.

As the cost of an ozone generator and material is small, every ship and steamer carrying passengers ought to be provided with them.

If cities can be lighted with the brilliancy of the sun by electricity generated by the revolving wheels and bands of an engine, why may not electricity, generated by other engines, be collected

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and discharged in successive concussions sufficient to charge the atmosphere constantly with ozone, so that the air of cities may be as pure as the air of the prairies and mountains.

From whatever source obtained ozone is a most powerful oxidizing agent, and fatal to animal life, except in small quantity, also destructive to textile fabrics and to colors, requiring great care in its use as a disinfectant. Its presence in the atmosphere may be detected by using white paper moistened in a solution of iodide of potassium and starch. By double electric affinity the ozone, uniting with the potassa, frees the iodine, which unites with the starch, giving the blue iodide of starch.

For disinfecting cargo in quarantine, as yet not anything has been found more efficacious and easy of application than sulphurous acid produced by burning sulphur. Bisulphide of carbon may be used in place of sulphur, but is far more expensive and attended with some danger.

Chlorine is a powerful disinfectant, and may be used with advantage in disinfecting cargo. It must be remembered that chlorine, from whatever source obtained, possesses so strong bleaching powers that most colored fabrics are affected by it.

Three parts of hydrochloric acid mixed with two parts of binoxide of manganese liberates the chlorine, which readily diffuses itself through an apartment.

Binoxide of manganese and chloride of sodium mixed in equal parts, upon which pour two parts of sulphuric acid, evolves chlorine, and also chloride of lime and hydrochloric or sulphuric acid in nearly equal parts. A more elegant but expensive way is to add sulphuric acid to chlorate of potassium.

Bromine and iodine are also strong disinfectants, and convenient in use, but the expense is so great as to preclude their use extensively.

The whole subject of disinfectants for the prevention and suppression of contagious and infectious diseases is an important and interesting one, but as yet their use is almost entirely empirical, and must be until the cause, the seed, the nature of disease, is better understood. We speak of the germs of disease. How much do we really know of them?

Animalculæ, spores, fungi, bacteria, micrococcus, microdemas

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have been supposed to be the cause of that class of diseases named zymotic.

When it has been proved, demonstrated that certain specific microscopic germs, whether of vegetable or animal origin, cause specific disease, then shall we have a basis upon which to construct a system of scientific disinfection.

If the intelligent, educated, skilful physician, by the use of medicine, has saved thousands from suffering and premature death, the more accomplished physician, who shall discover the origin and development of morbific matter and the means to render it inert, shall save tens of thousands, not only from premature death, but from all sickness and pain.

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THE CORDON SANITAIRE.

By R. E. Caruthers, M.D., Allegheny City, Pa.

The object of all quarantine laws is to prevent the spread of contagion; first, by ingress from infected localities; and, second, by egress from a location already infected.

The attempt to carry out the latter indication,—to localize the disease and to destroy it in its incipiency,—has called into existence the cordon sanitaire.

The term is borrowed from military parlance and is defined as "a line of troops or military posts on the borders of a district of country infected with disease, to cut off communication, and thus prevent the disease from spreading."

The first mention we find of such a measure was during the reign of Charles II of England, in 1665, where, during an epidemic of the plague, "a guard was placed over each infected house, day and night, and a large red cross, with the words, 'Lord have mercy on us,' painted on the door."

The cordon sanitaire can be applied most effectively in sparsely settled countries, where cities and villages are far apart, and where the approaches to them are limited to certain routes and passes. This condition obtains in Southern Russia, and in that country we have had, but recently, an illustration of the efficiency of the cordon sanitaire. The district of the Wolga, being infected with the plague, a military cordon was established around it, and, by the most stringent measures, the disease was prevented from spreading to other villages. By using the same efficient means the cholera, which formerly made periodical inroads into Southern Europe by way of Turkey, has been kept in abeyance and its ravages lessened.

The advantage in making use of the army for this purpose

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lies in the fact that it is always available at short notice, is well disciplined, and, being without local bias or prejudice, the orders given will be faithfully and promptly carried out.

In comparison with other forms of quarantine service the cordon sanitaire, embodying as it does, the principle of complete isolation of individual, family, village or city, is of primary importance. Were it possible to take the first case of a contagious disease that appears in a community and immediately surround it with proper precautionary measures to prevent communication with the outside world, the life of an epidemic would be destroyed in embryo, and the further prosecution of quarantine measures would be unnecessary.

In all contagious diseases we should recommend isolation of the patient. In the more severe and fatal epidemics this measure should be rigidly enforced, and, upon the occurrence of either of the four diseases which are recognized in this country as subject to control by quarantine regulations, viz., small-pox, ship-fever, yellow fever, and cholera, the most extreme measures should be resorted to to prevent communication with the community at large.

The attempt to carry out the principle of isolation is difficult. That it can be done has been proven. I might mention one instance that came to my personal knowledge where, during an epidemic of small-pox in our city, a family was, by order of the health-officer, forbidden to go off their own premises, and for about four weeks no one was allowed to enter the house but the health-officer and the physician of the health board. There are, often, influences brought to bear to prevent such stringent rules, but this shows that, if necessity demanded, perfect isolation could be accomplished. In this instance the orders of the officer were sufficient; but often a system of police would be necessary to accomplish the same object.

In case of an outbreak of an epidemic in a small village, especially when not on a line of railway, the task would be comparatively easy. A guard composed of five or six men would be enough to watch all points of exit and, if armed with proper authority, could prevent the scattering of germs of disease through the surrounding country and towns.

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But it is in relation to our greatest plagues, such as the yellow fever, which has so recently afflicted our Southern States, that this measure assumes its greatest importance. Without stopping to discuss the question as to whether the disease is imported or whether its germs are lying dormant in each of our Southern cities, only waiting for a favorable combination of atmospheric influences and insanitary conditions to breed pestilence and death, our object is to take it wherever and whenever it appears and, by proper means, confine it to its starting-point and prevent its spread.

To do this presupposes an already established, vigilant, sanitary service on the *qui vive* for the first sign of trouble. Supposing that such is already in existence we would suggest that, in the season when such epidemics may be expected, daily reports of cases of sickness should be required. Let this be required under severe penalty for failure to do so. On the report of a case which is at all open to suspicion, let the patient be seen by a medical expert, who shall decide as to the character of the disease. If he considers that the disease is one likely to become epidemic, let not only the patient, but all who have been in attendance, be removed to a suitable place on the outskirts of the city and retain them there until the incubative period of the disease has been passed. If no further signs of the disease are manifested they can then return to their homes.

If, in spite of the precaution taken, the disease should spread, or if it should appear to arise from several *foci* about the same time, it would then be time to establish a sanitary cordon around the city. If this measure is decided upon it must be done promptly and without any previous public notice, or its object will be defeated by the stampede of all who may wish to leave. If the necessity is grave, no one should be allowed to leave. If the disease has only appeared in certain well-defined localities, persons residing in other locations may be permitted to depart. When we say no one should be allowed to leave, we do not mean that refugees should be treated as was done in Vicksburg, we believe, where they were sent back into the city to die, but our ideal cordon would be established as follows:

When the measure is deemed necessary let a circle with a

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radius of at least five miles be established around the city. At every point where this circle intersects a railroad, wagon-road, river, or any other possible path of exit from the city, let a sufficient guard be placed to prevent egress. This guard should be composed of soldiers, for, aside from the advantages of using the army mentioned above, there is a moral force attaching to a uniform and glittering bayonet that commands more respect than any official not so clothed can expect to receive. At these points there will be no hindrance to passengers, baggage, mails, and freight entering the city, but the former must be made to understand that he who enters must leave behind all hope of return. By fixing these stations at this distance from the city ample room is allowed for those who wish to leave the densely settled portions of the city to isolate themselves from those afflicted. Those wishing to leave can, by remaining under inspection until the incubative period is past, be allowed to proceed. At these points all out-going baggage, freight, and mails should be removed from the conveyances bringing them and be thoroughly disinfected. No vessels, cars, or wagons which are employed to convey goods should be allowed to pass beyond these points. In short, these stations must be the barrier through which the outside world can enter if it desires, but beyond which the inside community cannot pass. In this way there would be no necessity for any increase of suffering or want, for the doors would be freely opened inward and anything needed could be received without any delay. At the same time that this is being attended to, proper hygienic measures must of course be adopted with the view of placing the city in good sanitary condition and eradicating the disease.

These measures may seem to be too stringent, but we believe that if they were carried out as strictly as possible, there would not be any increase of the disease attributable to this measure in the infected town, and it would most certainly be the means of saving other towns from the scourge. In the epidemic of 1878, if the infected towns had been surrounded by a sanitary cordon, strictly enforced, there would not have been such a tide of refugees flowing from them, and many towns, Grenada for instance,

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would have escaped the terrible disaster to which it was subjected.

Such a sanitary cordon should be continued in force, rigidly, until the disappearance of the disease; not only until the last case has recovered or died, but until the period of incubation has elapsed after the recovery or death of the last case. It may then be released with safety, after the thorough disinfection of all buildings, cars, boats, etc., that have been used within its bounds.

While we earnestly hope the necessity may not again arise for the use of such measures, yet it behooves us in times of peace to prepare for war, and this procedure should be well considered and steps taken by which it could be speedily arranged should the occasion demand. That the measure would not be popular we well know, for it is in direct antagonism to the usual law of life, which is not the Golden Rule, but "every man for himself." The laws make us responsible for any damage done by us, either wilfully or by negligence, to our neighbor's property, and we are morally, if not legally, responsible if we allow others to suffer illness and death from our neglect of proper means of preventing our diseases from spreading.

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THE LOCATION AND SANITATION OF QUARANTINE STATIONS.

By Louis A. Falligant, M.D., Savannah, Ga.

In discussing a limited subject like that which heads this article one is so apt to run off from the thing to the person, from the *station* to the unfortunate *occupant* of the station, that I trust my co-laborers will pardon me if at some unguarded point I appear to trench upon their province.

Quarantine is not a remedial agent in disease, but a method of checking its spread, and is therefore only applicable to the individual or the community, in so far as may be deemed advisable to protect the well against poison emanating from the person of the sick or from infected material, such as clothing, bedding, etc. In this sense, which is its only intelligible use, its severities fall on individuals or communities as may happen in the precautionary measures adopted to prevent the spread of contagious or infectious diseases. Viewing it then as a harsh remedy, however necessarily employed, it becomes us as physicians to use all humane endeavors to mitigate its pangs to whatever extent we safely can whilst not defeating the object of its employment. In this light we must study the location and sanitation of quarantine stations. First, their location.

It has not infrequently happened, more especially in malarial districts of the country, that the quarantine station or hospital has been carelessly located more with a view of getting the sick out of the way of doing harm to the well than with due consideration as to whether the spot was a fit one to which sick persons should be carried. It is against a careless humanity of this kind, perhaps I should say a heedless inhumanity, that we should most earnestly guard ourselves. No person should be

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carried or forced into a spot made sickly by natural or artificial causes, for we cannot justify ourselves in inflicting increased danger on the already afflicted subject whom we isolate to shield others from danger.

So then no locality should be selected for a quarantine station which is within the scope of miasmatic exhalations if another locality of a better fitness is at all within practical reach. I can scarcely conceive of any circumstances which would justify us in thus perilling the lives of the unfortunate sick thus forced into isolation. We should therefore avoid all swampy regions or the borders thereof, as well as the lower levels in the neighborhood of some "cities set on hills."

In regard to coast cities the quarantine station should be located adjacent to the lines of water communication, not immediately in the line of general travel, but perchance on some inlet of easy access at all times, and in such position as to secure good ventilation, good drainage, and pure drinking-water.

In the matter of interior cities or towns it should be several miles away from the thickly settled localities, but conveniently accessible by water-way, railway, or roadway. In all cases where practicable the station should be below rather than above the tidewater locality of the protected city or town. This will be specially apparent because of the danger of infectious material being conveyed by tidewater down stream with the current from the hospital.

It is necessary also to give heed to the general prevailing direction of the winds at such seasons of the year as are liable to give us need of these stations, and, if possible, to so locate them as that the prevailing winds will waft their exhalations away from and not towards inhabited localities. This suggestion may also be applied in the location of the stations in such manner that winds passing over malarial regions may not render the stations uninhabitable.

The *distance* at which a quarantine hospital should be placed from other habitations is another matter deserving serious consideration, inasmuch as our fears often govern us as much as our judgment. It is perhaps an excusable comfort to us to know that we are a good way off from a case of yellow fever, small-

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pox, etc., and more especially do we desire the distance lengthened when several cases of disease combine to poison the surrounding atmosphere, or furnish additional poison to be wafted across adjacent spaces to approximating dwellings. In our present knowledge of the specific poisons, whether they be considered as contagious or infectious, whether they be germs, miasms, or septic exhalations, whether they be spread by the person or by fomites, we deem it wisest to err on the side of safety, and give the healthy the benefit of any doubt as to the mode of propagation of disease, and to isolate all persons sick with such diseases as appear capable of transmission by any method from the sick to the well.

I do not imagine that it is so necessary to remove from an inhabited locality cases of measles, scarlet fever, diphtheria, small-pox, etc., as it is to remove cases of yellow fever. In the former, where proper measures of isolation and disinfection are adopted, experience teaches us that we have little reason to apprehend their further spread. But the poison of yellow fever, more especially when developed into *epidemic* influence, appears to possess a subtle quality of transmission by the atmosphere beyond the scope usually attributed to other infectious poisons, and to only undergo sufficient dilution to destroy its propagation intensity by the intervention of sufficient ventilatory space between its foothold and adjacent susceptible material.

I have known the poison of small-pox to be wafted from the second story of one house across a space of sixty or seventy feet into the second story of another house, and thus infect a new-born babe. But I have never known it to cross such open spaces as are referred to by Dr. Chaille, in connection with the transmission of the yellow fever poison from vessels *off shore* in the Mississippi River.

In this matter of distance, therefore, I should think that small-pox hospitals might be safely located a mile from inhabited towns or cities; but yellow fever hospitals had better be five to ten miles away. When it is remembered how intimately associated with malaria the yellow fever poison sometimes exists, and how malaria is carried on the wings of the wind across open spaces miles from the ground of its origin, I think my associates

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will hardly condemn the distinction I make in the different forms of contagious or infectious poisons.

My friend, General George P. Harrison, a former rice planter in this country, once narrated to me an interesting experience of his own in connection with the location of his negro cabins, at the end of an open narrow fieldway, some two miles back from the ricefields, but exposed to a current of miasmatic poison which traversed this funnel-way from the ricefields into the highlands. So much sickness existed in these dwellings that he was compelled to remove them out of the line of this open way, and as a consequence the hands again enjoyed good health.

I have now come to the second part of my subject,—the sanitation of Quarantine Hospitals; and if in treating of it I shall apppear *bluntly brief*, my colleagnes will undoubtedly credit me with that quality of difficulty which compels me to a separation of ideas which in the physician's mind almost uniformly merge into each other,—the separation of the *station* from the unfortunate occupant of the station. In locating a station for quarantine purposes so much consideration must be given to the subjects already referred to, that little is left to be done except to indicate how the place itself should be arranged; and this leads us to the construction of the first necessary outfit,—the buildings. These should be the physician's residence (if he is to live there), the residence for other attendants, the kitchen, the wash-rooms, and the buildings for the sick. These latter should always be one story wooden dwellings, having not more than one or two rooms each, and well arranged for ventilation. I do not think that more than one patient should be placed in any sick-room, especially in the case of yellow fever; for it is plainly apparent that the condition and chances of recovery of the patient are seriously influenced by the crowding of cases, the introduction of the more malignant features of bad cases into rooms where existing cases were previously milder, and the sympathetic dismay transmitted from one case to another in sight or hearing. A very interesting exhibition of this fact will be found in my "Report on the Epidemic of 1876," published in the May number

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of the *North American Journal of Homœopathy* for 1878, viz., "Case VI and others."

During the epidemic above referred to I had occasion to separate, to adjacent rooms, an aged husband and wife, who were both down with the fever, and who were literary grunting each other to death. Married for many years, and never before having slept in separate rooms or beds, they protested vehemently against the cruelty of my instructions, but my tender heart led me to insist on the change, and soon their sympathetically anxious condition was, by this isolation alone, changed to a state of mental quietude, and both recovered to return once more to "love's fond embrace."

Changing of the clothing and bedding of the patient, with sufficient frequency to secure personal cleanliness, is another necessary adjunct to the successful treatment of disease. Especially is this so in yellow fever, particularly after the sweats of the fever have saturated them with its rank-smelling effusions. I have yet to see any case in which the observance of this natural law was of any injury to the sick.

The excreta and vomita should be placed in earthen vessels and thoroughly disinfected before being thrown out. Nor should they be emptied into unventilated sinks or dry wells. Whilst I saw cases of yellow fever in 1877 which, to all appearances, were caused by exhalations from these unventilated dry wells, I do not recollect having seen a case which could be attributed to exhalations from any of our open-mouthed outdoor privies—this very peculiar fact being explicable only on the theory that the destruction of the poison emptied, in 1876, into these open vaults was due to their ventilated condition alone. This fact also militates against the "germ theory" of the yellow fever poison, since there is no reason why germs (if they existed), buried inches deep by the superjacent contents of the privy, should not break out (or *sprout*, as some say), from one or more of these thousands of privies quite as easily as from a sink or dry well, yet it has not been so observed. We are here again almost driven out of our special province into a suggestion of the character of the yellow fever poison, all the more because of the remarkable *calm* of an unventilated sink or dry well with

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its gathered foul gases, and the equally remarkabe calm and foul atmosphere so often observed in precedence to yellow fever epidemics; but this is neither the time nor place for such suggestion.

The general hygienic arrangements of a hospital, such as water supply, diet, etc., are so obvious as not to require further reference; and I will, therefore, conclude with the expression of a hope that these few rapidly written thoughts may possibly be of some service to those less familiar with the necessities of the subject.

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APPENDIX.

DISCUSSION.

FIRST DAY—EVENING SESSION.

Dr. Dake, of Nashville, Tenn. *Mr. President:* I wish, sir, to express my pleasure as to the manner in which the subject has been divided and presented to this body. If the subdivisions of the subject made were written upon, the papers when brought together would give us a treatise upon the subject of quarantine perhaps the best extant. This is a subject upon which the American mind has been especially active during the last two years. When we have had epidemics of Asiatic cholera in this country, attention was not given and the public mind was not so much excited as to these matters of quarantine. I wish to say a few words upon some points brought forward. I was especially pleased with the first paper. The remarks made upon the subject of isolation—personal isolation and disinfection. Many curious facts were developed during the late epidemics of yellow fever in the South by persons leaving points infected and going to other localities not having the disease, but leaving their clothing off and putting on fresh clothing, and leaving the place and not having the disease at all at any time, and yet persons taking up that clothing that was laid off, taking the disease and dying of the yellow fever. Therefore the measures recommended by Dr. Beckwith in his paper are highly important. It is highly important that the clothing of persons coming out of those places infected should be shed, and not only shed but destroyed. If not destroyed, very thoroughly disinfected before being used again. It is a common remark where the fever has been that it is not the person, and it is not the body that carries the disease, but the clothing, the bedding and things around, that have been touched by persons that had come in contact with the germs and seeds of the disease. In the city of Memphis, last year, when the first case of yellow fever occurred, so far from isolation being practiced, persons took the street cars and

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called at the house of the sufferer, and inquired after his condition, and went back into the street car and mingled with the people, and passed into the city again, and shortly afterwards there were other cases reported here and there, in different quarters in the city. In the city of New York, in the year 1819 and 1822, when the yellow fever appeared at that point from the shipping, it spread up into the city, and a fence—a high board fence—was built from river to river, cutting off the infected district, and communication was thus stopped, and the disease did not pass beyond this cordon sanitaire. This shows what may be done, and what may be done with the initial cases, and the first points of attack. In regard to quarantine, your commission, appointed to look after the yellow fever at the beginning of 1878, were of the opinion that a very rigid quarantine, a preventive — an absolute preventive — quarantine should not be instituted, but a discriminate quarantine.

Dr. Bowen, of Indiana: The papers that have been read have been very interesting indeed, and the subject comes up in my mind, on which I would like to have a discussion, and that is, in reference to the destruction of the clothing of those infected by the disease. Is it to be done by burning? I think that we ought to have that matter settled now and forever. First, I remember one instance occurred in Norfolk, Virginia, in 1855, when the yellow fever broke out there. There were three cases. The clothing of the patients affected was burnt, and after that there were thirty-five cases, which occurred in less than 48 hours. I have known several cases of small-pox, from burning bedclothes, where the smoke drifted down in that line, and in no other. My impression is that bedclothes infected by the yellow fever or any other contagious disease, must not be destroyed by fire, but should be destroyed by chemical means. My impression is, and I think time will demonstrate that I am right, that yellow fever instead of being destroyed by burning the clothing, will be spread by that means more than from natural causes. Heat expands and disseminates, and spreads the contagion. I am sure that whenever you heat a room where a sick person is confined with yellow fever, that contagion and infection will spread from there. Congelation prevents infection. Heat will expand. If you burn the clothing of a person who has had cholera or the small-pox, you will certainly expand it. The question ought to be settled now whether the clothing should be burned or destroyed by chemical means. I would ask Dr. Beckwith in what manner he proposes to do this, and what process he would advise for the destruction of this contagion.

Dr. D. H. Beckwith: I would advise the use of large vats

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with sulphuric acid for the purpose of destroying the clothing; it can be done in this way. The clothing can be buried. I think Dr. Bowen is right as to the burning of the clothing and as to the influence of the smoke. I think that the clothing should be destroyed by chemicals; we will then have no trouble with the smoke.

T. S. VERDI, M.D., Washington, D. C.: I would be very glad to say a few words on this subject of disinfection by fire. This has been mentioned by the gentlemen who preceded Dr. Beckwith. The trouble with this method is that we don't apply the fire thoroughly at all. When contagion is combated after such an application as that, the matter which flies up conveys the contagion. It is not burnt; if it was burnt it would not carry the contagion. There is the only difference between those who burn clothing in the manner in which they don't succeed in burning all the particles of clothing. Some of them are not burnt, and are blown away, being carried by the smoke into the air, and in that way the contagion is spread. You cannot destroy the contagion from the clothing without burning the clothing, except you use some chemical appliance. This was done in Liverpool, and in several places in England. They have an edifice built for the purpose, where they apply three hundred or four hundred degrees of heat without destroying the texture of the clothing, and yet they destroy the contagion. That has been applied in Washington for the destruction of contagion of small-pox, and it has been found possible to disinfect a mattress, or any such material without burning and without destruction. In Washington, during the epidemic of small-pox, in which I had under my charge fifteen hundred cases, not having the appliances or the money to build ovens or such places, the clothing was burnt by a charcoal fire, and in that way the contagion was very effectually destroyed. But the principal way is to build ovens; they are very easily constructed. The destruction of the contagion is accomplished by means of gas. The ovens are heated to an intense degree. This intense heat will destroy any contagion without destroying the texture of the clothing. When you come to destroy the clothing you affect very seriously a large number of poor people, because I have again and again done that very thing to a poor family; I have had the bed and bedding and everything destroyed. That is a very severe thing, particularly when it is done in the winter-time. We had no means—no appropriation to replace them at once. We burned in Washington about $22,000 worth of clothing of these poor people. I took the precaution to take their names and the approximate value of

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the clothing, and finally went to Congress and got an appropriation to pay the poor people. It was three years, however, after these poor people had lost all that they had before they were paid. Therefore I think that these ovens should supply the necessity of this general destruction by burning.

DR. TAYLOR: *Mr. Chairman:* Speaking of the papers of this bureau reminds me very much of a little anecdote which no doubt many of you have heard. Washington Irving relates that there was a dispute between two parties and they came before Squire Von Twiller. The case came up before him, and after hearing the testimony on each side, and taking an hour or two to smoke his pipe and think the matter over, he finally took up the two accounts and weighing them very carefully, for the purpose of deciding from their bulk and weight, he found them to be of about equal weight, and he decided that one offset the other, and so he made up his judgment, and it was that the constable should pay the cost. It seems to me that in reading over this paper that the chairman of the bureau had acted something after the method of Squire Von Twiller, that is, he had selected six articles with reference to the bulk of the article, and not from the scientific value of the same. Three of them favored the idea of diseased germs that were propagated by atmospheric influence, three of them were opposed to this view. Three of them were in favor of rigid quarantine, and three of them decided that quarantine was not available in the advanced ideas of our present time. Now it seems to me that that leaves us in a very pleasant and agreeable situation. We are all supposed to be advocates of both kinds of theories, and we find that both kinds of theories obtain in their arguments, and I may say too that both positions are well sustained by the arguments; but, sir, there is one thing in the first paper read to which I wish to take and make a decided objection. That is, the idea which seems to gain ground in certain quarters, that a central bureau of organization, representing a third of the United States, has expressed all the opinions that can be held in regard to this matter, that United States officials should be clothed with the authority to enforce their own regulations within the borders and precincts of the States. The idea conveyed, sir, is that this Central Board, or board of United States officials, must possess a satisfactory knowledge and a local knowledge; they must have all the local knowledge which is supposed to be possessed by local boards and the State boards. From their position as United States officials they have within themselves a satisfactory possession of the facts. They possess a satisfactory knowledge; that is the inference. Now I do not know upon what ground the

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gentleman bases his opinion, but it is a fact that such a suggestion would be utterly impracticable. It is a fact that in those States where these quarantine regulations are most especially needed that no such method could be adopted, because it is against the legislative thought and manner of thought in those States. To be interfered with by United States officials would not be tolerated. I venture to say, sir, that in the State of Indiana, the State that I have the honor to represent, such an interference on the part of a quarantine officer, or a recommendation from the United States board of officials, would not be regarded. It is also my opinion that people in South Carolina, North Carolina, Georgia, Florida, Louisiana, and Texas would take this same view of the matter. This is the subject I wish could be presented before us in our deliberations here. We sometimes forget that when we bring up questions for discussion here to go out to the world, that they go to every part of the country, and they are talked about and discussed, and we should endeavor to be eminently practical. That is the only method we can pursue; our thoughts should be practical.

Dr. D. H. Beckwith, Cleveland: I think in my paper I did not state that this government should have official authority. The gentleman who has just left the floor spoke on that point. In reference to that matter I would say that if the State of Indiana should be visited by the yellow fever or by the cholera that then they would insist on some such measure as has been presented. Yellow fever, if it should break out on the borders of their State, would be dreaded by them as much as it is by the citizens of any other State, and I do not think it would take them long to agree in reference to the best method of stamping out the epidemic. As I said, the government should have a man who is thoroughly qualified; a man who is thoroughly capable of understanding sanitary rules and requirements of this kind. I think then that the Governor of Indiana and the Governor of Tennessee would make up their minds that these rules, made for the rest of the people of the United States, must be carried out, and carried out to the fullest extent. That is the only way that we can get a thorough quarantine. When this matter is understood this will be accepted as the true method of dealing with a pestilence. They will not think then that this is a matter in which the United States has nothing to do.

A motion was here made to allow Dr. Verdi to speak again on this subject.

Dr. Allen: Where will that end if it is commenced?

The question being on the motion to allow Dr. Verdi the privilege of speaking again, the chair was in doubt, and a division

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was called for, which resulted in 25 ayes and 9 nays. It was therefore declared the sense of the Institute that Dr. Verdi should be permitted to speak again.

T. S. VERDI, M.D., Washington, D. C.: I shall not detain you very long and I apologize for rising the second time. But the gentleman strikes a question of state rights, which of course every good American citizen is perfectly well acquainted with. The idea of having a National Board of Health, or whatsoever name you might choose to give to the sanitary authority. The idea of the government of the United States interfering with the States is not because the gentlemen composing the delegation of the United States are more able or more learned than those who belong to the State or to the city; it is because of the local interests which interfere with giving that knowledge to the public which is absolutely necessary in order to prevent the spread of the contagion. Almost all of our epidemics have been spread from the desire of keeping them secret from the people, from commercial interests. It is a decided fact that this very last epidemic when Mr. Clark was brought to New Orleans from Cuba with the yellow fever it was kept quiet, and it is only when these cases are quite numerous and are alarming that the local authorities begin to show their apprehension and alarm, and then it is too late. That is really the reason why there is a necessity for a national supervision. Now allow that a disturbance takes place in a State during the continuance of an epidemic. Who does not remember the shotgun quarantine gotten up by any number of persons, whether official or unofficial? Why it is almost a revolution. It is total disorder. When such epidemics occur they interfere with everything and a panic occurs, and who is going to maintain order between the States. The question is a very important one, the matter of State lines and the difference between the States, but there is no power between the States except the United States. Nobody can interfere. A man coming from one State and going into another State cannot be interfered with unless it is by the United States. Commerce is the great means of conveying these epidemics. This is a matter that falls purely within the province of the United States. According to the Constitution of the United States, it is absolutely impossible to stop an epidemic in any country unless there is one head from which the orders, the rules and regulations can emanate. We have had experience even now with our present board of health. The local interests are always fighting the idea of a quarantine until it is impossible to stop the epidemic. After it has taken such a control in localities that it cannot be stopped, then they begin to see the necessity for a method of prevention.

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The question has been up all winter in the House of Representatives and these arguments have been used. I am happy to say that the members from the Southern States, the men who have suffered, and who know what a scourge it is, are in favor of the national quarantine. I will here say with great pleasure, and mention the name of Senator Harris of Tennessee, as being at the very head and front of this national quarantine. These gentlemen of the South can testify to-day of the interference they have had from this National Board of Health. The only interference they have had has been the one hundred and fifty thousand dollars that the National Board of Health has put into their hands to enable them to carry out their own rules and regulations. Even the city of New Orleans applied to the board of health last summer for the sum of sixty thousand dollars to enable them to sweep the streets of New Orleans, and they got it. The duty of the board of health is to assist and consult with them. It is not always to force, except where it is absolutely necessary for the protection of the neighboring States. At any rate, even if the United States is obliged to use force, it is a great deal better than the revolutionary and disorderly shotgun quarantine that we experienced last summer. Applause.

Dr. Jonathan Pettet, of Cleveland, Ohio: It seems to me Mr. President, ladies and gentlemen, that considerable time has been consumed in reference to the means employed for disinfecting clothing. If the clothing is burned it is a great tax on the poor, a tax to which they should not be subjected. We all know that diseased germs will stand continued dry heat at quite a high degree of temperature. Therefore it appears that it will be necessary to char the clothing and render it unfit or totally useless for future use. This can be easily avoided by using superheated steam. This could be used very easily by the government in disinfecting ships and anything of that kind. It could also be employed for disinfecting clothing. It would be impossible to have the apparatus distributed through the different States. The clothing could be sealed up very well and transported to the places where the operation could be performed. This method would prevent the destruction of so much clothing as was represented to have been destroyed in the small-pox cases in Washington, by Dr. Verdi. And the great length of time which it took before these poor people could be reimbursed. When these things are properly understood and taken in hand by some authority which is competent, and one that has the power, these means can be properly investigated, and we will thus arrive at some way of doing justice to ourselves and justice to the nation.

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Dr. J. Edwards Smith, Cleveland, Ohio: I have been very much interested in the paper submitted by Dr. Beckwith, and probably he represents to a large extent a feeling that has possession of a large proportion of our people. There can be no doubt as to the propriety of using disinfectants, not only in cases of yellow fever, but in all similar cases—scarlatina and small-pox. There can be no doubt about the importance that attaches to that; but what I fear is, and what I rise to suggest is, a point that has not been presented to-night. In our efforts to use disinfectants we have been, to a large extent, careless of other considerations. Now there are a great many conditions connected with yellow fever. I have myself been through two epidemics; for one I have not been liable to take that contagion. I have been where I was told that no one could go, that they were dying around me at the rate of sixty a day. Now it is I think in yellow fever localities, such as will occur in Louisiana and Mississippi, that physicians who occupy the position of yellow fever physicians, and that is the point we ought to consider—we ought to consider it from that standpoint, the standpoint of the yellow fever physicians—they are the persons who have had large experience in this particular direction. It is one of their fundamental canons that that portion of the population who fear the entrance and commencement, or the advent, of an epidemic of yellow fever, are the very ones who are sure to take it, and not only take it, but die; while of the other portion there is always, to a certain extent, quite a proportion that neither fear it or care anything about it in any respect; as a rule they generally escape. Now we know also that parties who have had the square yellow fever (I do not refer to dengue and breakbone, or to that type, but to those who have had real yellow fever), that they are very proud of their recovery, and are exempt from further attacks. Therefore you see that there is a difference in the type of yellow fever; what is one man's yellow fever is not another man's yellow fever. After all I apprehend that the success is due to our homœopathic practitioners in that disease, from the fact that they treat the symptoms, while the allopathic practitioners take these symptoms in a lump, as they do generally. What I am coming at generally is this, not to lose sight of the symptoms. The nation has heard all about this subject, but still it should be discussed. The matter of disinfectants should not be lost sight of.

We should not lose sight of another thing which I fear we have neglected to a serious extent, and that is this: to find out what is the cause of yellow fever. My friend, Dr. Pettit, has alluded to the germ theory. Many of you will recollect Dr.

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Drysdale, one of our commission; it is enough to say that he is a microscopist, and a most diligent one. He has paid great attention to the advancement of the theory of the so-called yellow fever germs. You will also recollect that Dr. Bull has made quite a study, and published two or three books devoted entirely to the analysis of these so-called germs. But neither of them, neither has Dr. Drysdale or Dr. Bull, or any other investigators in this special line come to any conclusion. They have, all of them, failed to bring forth any theory, any germ theory, that is not seriously affected by conditions that we cannot generally very well explain. I mention this to call your attention to the fact that there is a large work to be done. We have got to have more experimenting, I think. Mrs. Martino, I think, or some lady of renown, in her receipt for cooking a fish, says, "first catch your fish." What we want first is to know and to have it demonstrated what God Almighty has created, and what the people have a right to demand of the medical profession is that they study at this matter until they find out how the facts are. First of all we have to settle down on one or two theories as to which of the two is correct; is yellow fever epidemic, or is it sporadic? Now sporadic don't mean anything; it don't mean proceeding from spores. I think we would say that that was more correct, but the appellation in localities affected by yellow fever the term is different; they use that term, but apply it to something that springs up of itself, something that comes into existence of itself, something that is not natural. Every one who talks of an epidemic speaks of it on the theory that it must be brought from an affected locality.

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REPORT

ON THE

BUREAU OF PSYCHOLOGICAL MEDICINE.

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A CAUSE FOR INSANITY, INEBRIETY, AND THE OPIUM HABIT, AND THE REMEDY.

By George F. Foote, M.D, Stamford, Conn.

The increase of these infirmities, as well as that of other diseases, calls for a more thorough investigation as to their production; as to what moves, excites, or impels to their effects; and, as it is the prerogative and especial duty of the physician, so far as within him lies, to anticipate, as well as to cure disease, he has in this direction, and in view of the consequences resulting from these calamities, an opportunity, both by precept and example, to fulfil the highest and noblest work of his profession. Here prevention has the priority in the field of good uses.

To be a physician is the assumption of a finite responsibility, pregnant with the vastness of a duty involving most of the essentials that contribute to health, happiness, and longevity.

In view of these facts, which every true-minded physician makes a prominent feature of his calling, we may profitably turn our investigations to the animus that controls our physical demands for building, replenishing, and preserving our bodies in health.

A good Providence, who is the all of wisdom, has endowed every animal with a natural appetite for the kinds of food and drink best adapted to their physical necessities, for growth and perpetuity. This, the instinctive appetite, which succeeds that of the maternal food, into which the animal is born, remains and exists always the same, from infancy to old age. The horse eats grass, hay, and grain when young, and with a similar relish and from the same necessity when in advanced years. The car-

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nivora, both old and young, eat flesh. There is no change of diet from any physical change in the demands of the organism.

Now man physically is but an animal, with all the natural instincts of his kind that an animal possesses. True he is endowed with reason, but this should only aid him in fulfilling the law of his animal life. Therefore, both in youth and in advanced age, like the animal he should be governed, in the selection of his food and drink, by his natural appetite—that appetite into which he was born, the instinctive appetite, without cultivation by any process of training.

But what are the facts in civilized and enlightened life? The child has no sooner left his mother's milk, than he is put upon a course of training, to abrogate and destroy his natural instincts for the kinds of food designed by an all-wise Providence for his sustenance and health. Aye, he is often fed from his mother's breast with milk made unwholesome by the various decoctions of tea, beer, and other compounded drinks, poured into the mother's stomach under a delusion that such beverages aid in the production of milk, thus forcing upon the infant food that, in comparison, has but little to recommend it above that obtained from the sickly cows fed upon the slops of a distillery.

The natural appetite craves and luxuriates upon the simplest kind of nourishing food.

The child, before being defiled by an artificial diet, has no love for pepper, spices, or mustard, or any of the stimulating condiments and sauces, so common upon our tables; nor has he for stimulating drinks, for tea, coffee, beer, whiskey, and its kind; neither has he for tobacco or opium. Any and all of these are offensive to him. But by cultivation, the force of example, and the natural desire to imitate his seniors, he, by a long course of training, loses his love for plain and wholesome food, and cultivates a love for quite the opposite; to gratify which, the food must be mixed with a condiment; something that irritates or stimulates is needed to get up a satisfactory relish; something to smother or disguise the natural flavor, for which he has lost that exquisite and pleasurable sensation, known only to those in full possession of the natural appetite. He seeks to gratify an artificial love, which, however much indulged, is never

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satisfied, but is ever enlarging to meet an abnormal demand, that grows like all other evils, with its indulgence.

This good and wise Providence, that created man perfect in every detail, a little lower than the angels, even after his own image and likeness, not only endowed him with reason, but also gave him a bodyguard, with sentinels placed in every conceivable part of his physical system that may be exposed to impressions. These are the nerves of sensation that report to the central power, pleasure, or pain, according to the quality of the infringing substances. And they are sensitive to the proximity of any damaging agency. Those upon the surface, for instance, will report the too near approach of an excess of caloric; we heed the warning and shun the damaging influence of fire.

The portal of the stomach, the mouth, is guarded by delicate nerve tissues, keenly alive, while in a healthy state, to the approach of all substances entering this cavity. They also dictate, through the sensation of pleasure or pain, the kinds of food or drink best adapted to man's necessities. They are the sentinels that inspect and report upon the quality and fitness of whatever passes this gateway. And their verdict should never be called in question. The stomach, while in a healthy state, never reports its abuses from the introduction of improper food or drinks, at the time taken, for the reason that it has no corresponding nerves of sensation. It depends entirely upon the nerves of the buccal cavity for protection from any of these substances.

It is of the greatest importance then that these monitors should subserve the uses for which they were designed by the Creator "who doeth all things well." And it ill becomes us to assume the prerogative of any attempt at an improvement upon his handiwork.

This animal instinct is an animal pleasure that cannot be altered without violating law, and we cannot violate law without suffering the corresponding penalty. Therefore the introduction of any substance into the mouth, or through it into the stomach, that in the least irritates, burns, nauseates, or in any way offends these guardians, or would offend them, if they had not been injured or destroyed, is all wrong, and suffering in some form in the end is sure to follow. Any symptom of dislike or suffering

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expressed by these nerves is a warning that implies danger. To injure them, so that they fail to report the presence of improper substances, is to subject the system to irreparable injury. It is suicidal, and yet in an enlightened and civilized country like ours we can hardly find an adult person that has not greatly injured, if not entirely destroyed, this provision of our Creator against harmful influences.

Most men and women can, with apparent impunity, take into the mouth the various irritating and stimulating condiments, as pepper, spices, mustard, the various sauces, curries, etc., and the exhilarating drinks, as tea, coffee, and other decoctions, while many have disciplined themselves to take raw whiskey and other alcoholic drinks; and all and each without that consciousness of suffering peculiar to a person in the full possession of his natural and healthy instincts and susceptibilities.

To the natural man these things would be highly offensive, as they would to a child in his youthful simplicity.

It is a great mistake to suppose that irritating condiments add to the gustatory pleasure of a healthy organism, or that they in any way promote digestion. To any one in perfect health no satisfaction is derived from their use, as they give pain rather than pleasure. Their presence in the system is ever followed by evil consequences. Here then is the primary source of many of the ills that flesh is heir to.

Here undoubtedly is the incipient beginning of that formidable disease, inebriety, that devastates our land with untold suffering. It is the embryo of a hydra-headed monster that is ever filling our homes and our hospitals with disease, and sending countless numbers to an untimely grave.

This is the upas tree, whose pestilential odors foul the very air we breathe, stimulating the nervous system, exciting the procreative organs precociously, and to an abuse that helps to fill our asylums with large numbers of the hopeless insane.

Intellectually man is superior to the brute. Physically he is under the law that governs the animal kingdom, with instincts of self-preservation common to all animals; physically superior only in being the microcosm of everything below him.

It is fair to assume that by analogy we may profit from the

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precepts and examples afforded us by the inferior animals, governing ourselves in many respects by their habits and instincts. We are not to infer from this that we are to eat straw like the ox. But like the ox we can eat to live, and like him should cultivate only the natural appetites into which we are born.

The ox eats straw because the good Providence has so constructed his organism that he finds it nutritious, and with his instinctive perceptions he discriminates the kind of straw that contains the aliment needed to build up and repair the wastes of his body, and this he eats with a relish that gives a pleasurable sensation in comminuting, ensalivating, and preparing it in the mouth while on its passage to the stomach.

And man is also endowed with the same faculties, the same appetites for the kinds of food best adapted to his necessities. An appetite that needs no "appetizers," the same gustatory pleasures, the same discriminating perceptions, that tell him distinctively and instinctively what he should eat.

Being endowed with reason does not change the animal functions within him. And the exercise of this superior faculty should never interfere to disturb the order and workings of this animal life.

We are all born into certain corporal necessities, and it is presumable that the Author of our being understood exactly the best means to the best ends, and that he gave us physically the best possible lives, the natural and proper gratification of which should contribute to health and a long life.

The new-born man then, we may safely conclude, was made perfect as to his appetite, and that we can best fulfil the ends of our uses by accepting a truth so apparent, and by conforming to a design infinitely superior to any change that we might make. And here let me add in the language of another that "it should never be forgotten that the universe moves in obedience to laws so wise and good that they never require to be amended, altered, or revoked. And it is the proper business of true science to work in harmony with these laws."

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METHOD IN PSYCHOLOGICAL MEDICINE.

By J. D. Buck, M.D., Cincinnati, Ohio.

Mr. President and Members of the Institute: A few days ago in looking over the "order of business" for the present session of the Institute, I discovered my name on the Bureau of Psychological Medicine, a very broad subject, indeed, upon which to report. I understand psychology to be all that relates to the structure and function of the nervous mechanism, the base of which is anatomy and physiology, and the crown metaphysics. Psychology, then occupying an intermediate position between the physical and metaphysical structures and functions of man, involves a very wide range of activities, and nowhere else in all the domain of knowledge, is there so great need of definite data, and precision of treatment, as just here, for the reason that the subject, by imperceptible gradations at either end, shades off into the material or the speculative phases of thought and investigation. Furthermore individual bias frequently predetermines both the method and result of investigation. Now while my sympathies are largely on the other side, both experience and observation show that the best results arise from those investigations in this important department which are predicated from and closely adhere to physical fact, or the purely materialistic standpoint. The history of philosophy furnishes ample proof of this statement, wherein speculation has ignored fact, only to be in turn overthrown by induction and demonstration. Surely the human mind evinces the operation of fixed laws, no less than the less complex manifestations of man's being, only, from the greater complexity of nervous and mental phenomena, these laws are not so readily apprehended. Systematic investigation has nevertheless been pursued, and great progress been made within

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the past two decades, though such laws as have been discovered have not been systematically formulated, except provisionally, while the fundamental postulates are not generally recognized or accepted by medical men, who ought everywhere to be the leaders in such investigations. The investigations of Herbert Spencer are just beginning to be recognized and appreciated, and to find their way into prominent institutions of learning, though even here they are not admitted without strong opposition, because they have a tendency to unsettle some of the ancient traditions. What, then, does the American Institute of Homœopathy mean by and include in the term "Psychological Medicine?" Probably no two of the eleven gentlemen named in the bureau would give the same answer to this question, beyond the statement that insanity ought to be included; but if we were to inquire what is insanity, certainly no two would give the same answer, for no two cases of so-called insanity are alike. I submit, therefore, that this whole subject is even here, in the American Institute of Homœopathy, in the year 1880, in its infancy and in confusion, and that whatever is done in regard to it ought to be done systematically. Many excellent papers have from year to year been presented, though without continuity or general agreement as to any one fundamental principle, each reflecting the mental bias of its author.

This bureau may be allowed to include nervous and cerebral structures, nervous and mental functions or phenomena, nervous and mental diseases, whether primary or secondary in their character. We should then come to consider the psychic force, its origin, manifestation, correlations, and co-ordinations, its quantity and quality, from a general physiological standpoint, and finally we might come to consider those pathological conditions which belong strictly to psychological medicine. But no individual life is long enough to go over and thoroughly consider all of these departments. The bureau, therefore, might accomplish for the Institute in a single session, the work of a dozen years of individual labor. Much will be gained by recognizing at the outset, that no such thing as a science of psychology exists, but that scientific methods in its pursuit are readily attainable, and we may be assured that this method will, ere long, if strictly

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adhered to, give us a science of psychology. Every physician knows that the mind affects the body, and the body the mind, in disease. While some will argue that the invasion of disease and the operation of medicines are always directly through the nervous system. Others again will take a more physical view of the matter, and so far as argument is concerned, it is doubtful whether anything new can be brought to bear by either party in the argument. Argument or philosophy assails the subject from the metaphysical point of departure, and however logically we may proceed, our premises are intangible and incapable of demonstration. The scientific method commences to investigate at the other end, viz., with physics and physiology, and passes cautiously from the known to the unknown, and when we reflect that even here, the plainest truths of physiology are very often unknown or rejected, here, where alone a basis of agreement is possible, we shall cease to wonder that more has not been accomplished in this department. Let me refer briefly to a few fundamental principles. Coincident with the elaboration of food in the process of nutrition is the development of psychic force. The great sympathetic system is the medium for the correlation of psychic force, intermediate between the nutritive and higher nervous mechanisms, as the lymphatics are intermediate between the digestive and circulatory apparatus, for the elaboration of material substances. The physical condition of structure wherever correlation of nerve-force occurs, either from lower to higher or from higher to lower, is that of relative simplicity or homogeneity. It is therefore as easy to trace the origin of psychic force, as that of living substance, for force and substance are never for a moment separated, except at the point of functional energy, the nascent point, when elevation ceases and disintegration begins.

Why may not the American Institute of Homœopathy place psychological medicine on this basis of physiological law, and make the volumes of its transactions valuable to all future explorers in this most important domain?

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MORBID VISION.

By T. L. Brown, M.D., Binghamton, N. Y.

Without organization we have no normal or morbid vision, thought, motion or existence.

Perception of forms in motion and the memory of the same constitute the normal and the abnormal visions of each individual. How can we be conscious of anything without a brain-form capable of motion and change of relation?

We have no vision independent of object perception or brain organization. The sensation motion of the brain is *our* idea of perception.

Thought is the nerve-cell motion record of object form and motion. How can we think of or view that which has neither body, parts, or motion? Every vision is or has been a brain perception of form or motion. Memory is revived similar perception.

The condition of the brain and its relation to quantity and quality of blood seems to control the phenomenon of normal and morbid vision. Arterial and venous blood in the brain, as to relative amount, modifies the manifestation of thought. No correct thought without a suitable quantity of arterial blood, in motion, in the firmly organized brain. No morbid thought without a certain quantity of venous blood in the brain, preventing normal nutrition of the brain substance.

What we see in our normal condition is our healthy vision. Conditions favoring the increase of carbon in the blood, through the lungs by inspiration in place of oxygen, favors in like proportion morbid vision in place of healthy vision. Then past perceptions seem as occurring first in the present time.

In the open air, in well-ventilated rooms, fed upon strictly

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physiological food, taking well-timed exercise and sufficient sleep, we find the most healthy people having correct vision and normal thought. In over-carbonized air, crowded rooms, the use of alcoholic drinks and drug poisons, lack of exercise and sleep, we find persons having morbid visions and insane thoughts. In drowning, drunkenness, carbonizing in close rooms, narcotizing with certain drugs, we observe carbonized blood in the brain in abnormal quantities.

Away from such carbonizing processes of the brain relations man is found with normal thought, recording the true history of events.

At a certain period while drowning, the former brain perceptions are reproduced. At a certain time, in a suitable quantity, carbon in the blood of an intemperate man reproduces a former perception, one which had once frightened him most. In a spiritual circle, held in a closed room, where bedquilts and blankets are placed over the windows and doors to keep out the moonlight and the lamplight, thus shutting out the oxygen and keeping in the carbon, thereby the sooner carbonizing the blood of each person in the room, the feeble, large-headed, small-chested female medium, after an hour's breathing of the carbonated air of such a room, declares she sees her *dead* aunt or grandmother. Eyes open or shut, in this darkness, her brain is under the control of a former perception of a normal vision which had once made the greatest impression upon her brain. Open the door, let in the oxygen, and soon she loses that *spiritual* sight. Close the door until the oxygen has again been mostly inhaled by the inmates of the room, and the medium will again see (as she thinks) her aunt or grandmother.

Is her said relative there? It is more reasonable to conclude that the carbonized blood, with the help of the darkness, shuts out normal vision, to make, for the time, a former perception control her attention.

Former frightful perceptions often make up the incoherent and jumbled mental ravings of the insane, pressed upon the brain by the action of an over-quantity of inhaled carbon gas. Loss of sleep and nutrition, in an ill-ventilated room, changes

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the normal visions of the brain by disturbing the proper supply of oxygen for the brain.

In all badly-ventilated church rooms, where the air for two or more hours has been gradually deprived of its oxygen and as gradually increased its carbon, by the number of persons present, the feeble, full of fear, go forward, converted under the increasing terror of their present and former religious education. Such converts lose their winter-carbon conversion when the summer air and sunshine better sustains the nutrition of their brains by a proper supply of oxygen and light.

Arterial blood, supplied with its due proportion of oxygen, continually sustaining its nutritive relations to the well-organized brain, constitutes and controls normal vision and correct thought. Venous blood in too large a quantity holds the brain in a state of fearful substitution, obliterating for a time the present consciousness, with only the most impressive perceptions of past events.

Opium-eaters, alcohol consumers, carbon inhalers in a state of bodily rest, deprived of the necessary amount of oxygen, soonest help to make up the number of those who dream the dreams of drug poisoning, spiritism and old tyrannical theology.

In the sunshine and air, active with bodily and mental work, we observe the scientist civilizing himself and the terror-stricken race.

Correctly record normal vision at the moment of its healthy manifestation, and we have the history of the true events of man in their sane and scientific completeness.

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REPORT

OF THE

BUREAU OF OBSTETRICS.

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ECCYESIS.

By C. Ormes, M.D., Jamestown, N. Y.

In investigating cases of supposed extrauterine fœtation, first should be the history of the patient herself in relation to her supposed pregnancy, and the events which have occurred from the time of her supposed conception to all the circumstances and symptoms from that time to the time of her expected delivery and after, and then the diagnosis will, in the early stages, be surrounded with difficulties, as we are seldom called upon to investigate the case until all successful hope of interference is past. The extra fœtation may be either tubal, encysted, or abdominal.

In cases of tubal fœtation rupture of the tube occurs about the third or fourth month, when the patient dies from intra-peritoneal hæmatocele.

In the early stages, and when we suspect the child may be enveloped in a sac of some kind and alive, we cannot determine that it is not in the uterus short of exploring its cavity by the sound or finger, which proceeding could only be justified by the urgency of the symptoms.

In the case reported the os was dilated with sponge tents by the midwife who was in attendance, and at my visit the examination could be easily made, either with the finger or uterine sound, and the uterus found to be empty, while there was enlargement of the bowels, but no distinct outlines of a fœtus could be detected, but distinct fluctuation on palpation of the lower part of the abdomen, where there had been something hard, as the patient expressed it, and where the motion was felt. Externally the abdomen presented a rounded protuberant appearance.

Mrs. H. Tweede menstruated 9th of July, 1879; has had two healthy children; never had a miscarriage or abortion. As there

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was no return of the menses, supposed herself pregnant, though less constitutional disturbance than in former like conditions. At about five months felt feeble motion, not as prominent as in former pregnancies, and continued until the seventh month, though feeble. At this time motion ceased, soon followed by uterine or abdominal pains, occasional chills and fever; supposed she was going to be sick. A physician was called in; patient feeling better, no examination was made. Ten days after, having more pain, and slight serous discharge, a midwife of their own nationality was called in attendance, and, patiently waiting upon the lady a week or more, and no more signs of labor coming on, made an examination. Found os not dilated nor dilatable, and uterus apparently in a normal condition; dilated the os with sponge tents, and on exploration the uterus was found empty, and of natural size. At this time first saw the case in consultation. On exploring the uterus confirmed her diagnosis of an empty womb, with a dead fœtus in abdominal cavity; for last four weeks has had chills, fever, pain and soreness of bowels, and constantly confined to her bed from the extreme tenderness of bowels. From her symptoms was well assured that at the time of the death of the fœtus an inflammation had been set up within the peritoneal cavity, and extensive suppuration had already taken place, and advised its immediate removal by abdominal section, patient and friends approving.

April 8th, nearly nine months from last menstruation, thorough anæsthesia being produced, a free incision was made from the umbilicus to near the pubis; continuing the incision in the line of the linea alba, found the abdominal parietes and cyst-walls perfectly amalgamated, presenting one dense mass of interstitial adhesion; going through this the cyst-walls were opened, and nearly four quarts of pus were discharged, and below was found the fœtus, which was removed in a partially decayed condition, but perfect in structure. The placenta lay over the fundus of the uterus and immediately surrounding viscera, to which it was attached, and was left in *situ*. Abscess was sponged out, wound dressed with sutures and adhesion straps, and patient put to bed; the anæsthesia passed off, and patient feeling very comfortable. Ordered perfect rest and quiet, and nurse to urinate

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her as often as required, which was strictly complied with until the ninth day, when, from pecuniary considerations, the husband decided to dismiss his nurse and officiate in that capacity himself. The first attempt to urinate her was a failure; after vainly attempting to relieve herself, failed and sank down exhausted. Twelve hours after the attempt was resumed by raising her upon a vessel, had a voluntary passage, and again sank down exhausted; a chill, followed by high fever, ensued, and on the twelfth day a powerful hæmorrhage from the wound, where opening for drainage was left in lower part of incision; bed completely saturated, probably from bursting of the enlarged vessels at attachment of placenta. Another inflammation was set up, with extensive suppuration, with free flow of pus from the wound.

Fifteenth day, septicæmic symptoms were rapidly developed, and all hopes of recovery gone, and lingered until the twenty-fifth day, when she died; and how very much to regret, that so critical and important an operation should have failed by the cupidity and pecuniary considerations of a—husband.

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IMPROVEMENTS IN THE ART AND SCIENCE OF OBSTETRICS.

By Geo. W. Walker, M.D., St. Louis, Mo.

Mr. President and Gentlemen of the American Institute of Homœopathy: As our time is limited, and as this is a utilitarian age, when we are all impatient to get at the gist or kernel of whatever engages our attention, I shall make no introductory—no prefatory remarks,—but proceed at once to give you, in as short and concise a form as possible, what I conceive to be improvements in the art and science of obstetrics.

I shall refer to only a few of the more prominent ones.

1st. *Cephalic and Podalic Version by External Manipulation, or the Bi-polar Method.*—Doubtless the observance of cases of *spontaneous* version first suggested the imitation of the same process by the hands of the accoucheur. It was shadowed forth in obstetric works many years ago, but to Braxton Hicks is due the credit of first laying down definite rules for it, and bringing it to the notice of the profession. As a rule the liquor amnii must still be there, for upon the mobility of the fœtus depends the success of the bi-polar method. This, however, is not always necessary. The hands of the physician should be applied simultaneously to both poles of the ovoid. Both hands may be used externally through the walls of the abdomen, or one may be introduced within the os uteri.

For different positions either hand may be introduced. There is scarcely a case of malposition that the bi-polar method is not of more or less advantage. The failure by this method does not in any way preclude a resort subsequently to any other method. By the application of this method, and taking advantage of postural treatment, I succeeded in turning a fœtus after the evacu-

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ation of the waters, and when the child's arm had protruded from the vulva for two hours. The case had been attended and abandoned by a midwife.

When I arrived I found pulsation in the prolapsed cord still strong, and I immediately placed the woman in a prone position, upon her knees and breast, with hips well elevated. With the left hand I pushed the arm back into the womb, and pressed up upon the shoulder, and at the same time pressing with my right hand through the abdominal walls down upon the head, which lay in the left iliac region. The breech receded, and the head presented at the brim, and in a half hour the child was born.

Taking into consideration the great danger of introducing the whole hand and arm within the uterus to perform version by the ordinary method, we may conclude this to be one of the greatest improvements of obstetric art.

2*d*. *Placenta Prævia.*—We used to be taught, and the error has not been altogether corrected yet, that we should temporize with a patient flooding from placenta prævia until we deemed it dangerous to her immediate life, and then introduce the hand, turn and deliver by the feet. Prof. Simpson's proposition to separate the entire placenta and wait for natural labor was a slight improvement upon the old method, and is still applicable in some cases. The laws now laid down for the treatment of placenta prævia are very different and more definite. Among the elite of the obstetric art, there is very little difference of opinion on this point, save in minor details.

If you are *sure* you have a case of placenta prævia, and there is a sudden and severe hæmorrhage, no matter in what month of pregnancy, premature labor is to be induced without any delay. If the child is non-viable, that is, previous to the seventh month, and the hæmorrhage is slight, and the os uteri undilated, we may temporize, recommending absolute rest, cold applications, and the use of specific remedies. If necessary, dilate the os by sponge tents, or better by laminaria tents, and follow in an hour or two with Barnes's dilators, or tampon the os and vagina, but only for an hour or two.

Be on the alert. Do not leave your patient for more than an

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hour at any one time. If there be any abnormal position, now is the time to rectify it by external manipulations. Remove the tampon or dilators, and as soon as possible rupture the membranes with a metallic or stiletted gum catheter, and draw off the water *gradually*. Do it *slowly*, or you may induce inertia of the womb. If the placenta is only partially over the mouth of the uterus, before puncturing separate the bleeding side with your finger, then reach above and draw that portion to the opposite side, or if central, and it resists the catheter, make a hole through the placenta first with a porcupine quill or its equivalent. As soon as the water ceases to flow through the catheter, withdraw it, and enlarge the opening with the finger. If the head or breech presents, put on a binder and use uterine compression. Ergot should be given unless the birth is a cross one. Promote uterine pains in every possible way, for if active labor comes on, hæmorrhage is impossible. If the head does not present, as is frequently the case, we should make the attempt to turn by the bi-polar method, and in case of failure introduce the hand and bring down the feet. To sum up,—in placenta prævia with severe hemorrhage, at any period of pregnancy, induction of premature labor is the rule; water to be evacuated slowly. In cases of mal-position, turn by the bi-polar method if possible, and keep ever in mind the extreme danger of thrusting the hand within the womb. Resort to it only in the last extremity. In cases where placenta prævia is complicated with other dystocias, the ordinary rules of obstetric art are applicable.

By the old treatment one in three of the mothers die, and more than one-half of the children. By the improved treatment not more than one in ten of the mothers are lost, and the mortality of the children is greatly reduced.

3*d*. *The Frequent Use of the Forceps in Hastening Labor.*—Within the last few years professional opinion upon the frequent use of the obstetrical forceps has undergone a marked change. Instead of an operation to be dreaded by the accoucheur, and a terror to the mother and of frequent fatality to the child, the ingenious construction of instruments and the increased knowledge of the mechanism of labor, have rendered it one of the safest and one the least to be dreaded of any of the operations belong-

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ing to obstetric art. Some of the professors of this branch of medical science, and the majority of the standard authors to-day, strictly prohibit instrumental delivery, unless all hope of nature accomplishing it is gone.

Arguments in favor of the more frequent use of forceps are so well expressed in the report of the Rotunda Lying-in Hospital of London, for the year 1872, quoted by Playfair in his *Treatise on Midwifery*, that I prefer it to my own.

"Our established rule is that so long as nature is able to effect its purpose without prejudice to the constitution of the patient, danger to the soft parts, or the life of the child, we are in duty bound to allow the labor to proceed, but as soon as we find the natural efforts are beginning to fail, and after having tried the milder means for relaxing the parts, or stimulating the uterus to increased action, and the desired effects not being produced, we consider we are in duty bound to adopt still prompter measures, and by our timely assistance relieve the sufferer from her distress, and her offspring from imminent death. Why, may I ask, should we permit a fellow-creature to undergo hours of torture when we have the means of relieving her within our reach? Why should she be allowed to waste her strength and incur the risks consequent upon long pressure of the head on the soft parts, the tendency to inflammation and sloughing, or the danger of rupture, not to speak of the poisonous miasm which emanates from an inflammatory state of the passages, the result of tedious labor, and which is one of the fertile causes of puerperal fever and all its dire effects, attributed by some to the influence of being confined in a large maternity and not to its proper source, *i. e.*, the labor being allowed to continue till inflammatory symptoms appear? The more we consider the benefits of timely interference, and the good results which follow it, the more are we induced to pursue the system we have adopted, and to inculcate to those we are instructing the advantages to be gained by such practice, both in saving the life of the child as well as securing the greater safety of the mother."

These are my views, and I believe they will ultimately prevail, for from my own observation the infant mortality is much less, and the suffering of the mother greatly reduced. Taking

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all classes of labor together it is said one out of 20 to 30 children is stillborn. Dr. Hamilton, of England, says that he uses forceps in every seventh or eighth case, and thus delivered 731 successive children without a single stillbirth.

4th. On the Manner of Introducing the Forceps.—Instead of passing the blades of the forceps as nearly over the child's ear as possible, and adapting them always to the bi-parietal diameter of the child's head, the rule now taught is to pass them in the transverse diameter of the pelvis without reference to the child's head. Make the pelvic curve of the forceps conform to the pelvic canal of the mother. The precise position of the head should, if possible, be ascertained by the accoucheur before applying the forceps, but it is by no means essential. If the forceps do not lock the fault is probably in one of two things, either the blades are not thrust far enough in, or the handles are not pressed back far enough against the posterior fourchette. With a properly constructed instrument, and applied as they ought to be, they should *never* slip.

5th. On the Non-ligation of the Funis.—After the birth of the child the cord should not be severed until pulsation ceases; then cut it and allow any blood which may remain in the umbilical cord to ooze out.

Before washing the child a ligature may be applied. Tying the cord is not, as was once thought, absolutely essential to prevent hæmorrhage. A ligated cord bleeds just as often as a non-ligated one.

6th. Delivery of the Placenta.—Until recently it has been the custom among accoucheurs to wait a very few minutes after the birth of the child, and if the placenta is not expelled to make traction upon the cord with one hand and with the other press upon the fundus of the uterus. With many the binder was to be put on as soon as the child was expelled, and before the delivery of the after-birth. A binder never promotes contraction of the womb. It is possible that it may to some extent secure a contracted womb from again dilating. A binder should not be applied previous to the expulsion of the placenta, neither should traction be made upon the cord, unless the placenta is extruded from the womb, and is lying within the vagina. The

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uterus itself should be made to expel the placenta. After we have waited twenty minutes, occasionally placing our hand over the uterine region to make sure that there is contraction of that organ, we may grasp the fundus of the womb in our left hand, pressing the womb downwards and backwards in the axis of the pelvic brim, when in almost all cases the placenta and its membranes will pass out. If it does not we may repeat the manipulation, and if it does not pass away for an hour or more no harm will come of it. The cardinal point to remember, as Playfair says, is that the placenta should be expelled from the uterus by a *vis a tergo* movement, and not drawn out by a *vis a fronte.* By this procedure post-partum hæmorrhage is less likely, after-pains are lessened, and the safety and comfort of the patient greatly promoted.

7th. Breech Presentations.—Let them alone until the body is expelled as far as the umbilicus. Traction should not be made upon the trunk to expedite delivery. In no case is meddlesome midwifery so bad, and in no case is the temptation so great.

8th. Fruit Diet in Pregnancy.—For the last six or seven years I have been in the habit of recommending to my patients, who were expecting within the next five or six months to be mothers, a diet consisting largely of fruits. As far as in my power, I keep them from eating those articles of food which contain a large proportion of earthy matter, such as wheat, beans, barley, oatmeal, etc. The flesh of *matured* animals, as beef, mutton, and pork are strictly forbidden. Those kinds of food which contribute largely to the growth of bone and muscle are to be taken in moderation or not at all. Of course no one particular system of diet will suit all; but it must from time to time be modified to suit each individual case. The fruit is essential, but in no case to the entire exclusion of either farinaceous or animal food. The diet which athletes or prize fighters adopt to harden their muscles, is not the diet for a pregnant woman; neither is the coarse diet of the laboring man.

Females of those nations who live principally upon fruits, as the Hindoos, Sandwich Islanders, etc., have easy labors; while the laboring classes of this country, who live upon coarse farinaceous and coarse animal food, have, as a rule, hard labors. Two-thirds

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of all the craniotomy cases in my practice have been among the lower classes of Irish.

I have had among my patients women who, with a vigorous digestion and sharp appetite, indulging plentifully in roast beef, mutton, and fried ham, with coarse bread and other hearty food, taking just enough of outdoor exercise to stimulate the appetite still further, and while apparently flushed with health and full of red blood, come to bed at the end of nine months and bring forth, with the most terrific sufferings, a child weighing eleven to fourteen pounds, and a head as hard and unyielding as a child's of six months old should be. From her good health and vigorous constitution she had anticipated a comparatively easy labor; but what a grievous disappointment. If she could look back over the nine months of pregnancy and realize the cause of her suffering she would feel thankful the life of herself and her offspring had not been sacrificed. The rule in such cases is forceps, craniotomy, or an inordinate amount of suffering, and often the death of the child or mother.

By a well-regulated system of diet, I tell you, from a tolerably large observation, this state of things can be to a great extent avoided. To my mind there is no sense in a woman having children beyond eight or nine pounds; nor in a child's head being non-compressible from an excess of bone; nor in a woman's muscles being as firm and unyielding as a prize fighter's.

The ambition of some women to bring forth large children should be cultivated and directed towards producing quality of fibre, rather than quantity. There is a large and fruitful field for cultivation by the medical profession in this direction, and I hope that some, if not all of you, may have your minds attracted to the subject of "diet in pregnancy," and ere we meet in the coming year, we may, from our varied observations, be able to mitigate to some extent the perils and sufferings of women in childbirth.

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PLACENTA PRÆVIA; A STUDY.

By George B. Peck, A.M., M.D., Providence, R. I.

Nature and Classes.—Nothing, not even *post-partum* hæmorrhage, tests more thoroughly the adaptation of a physician to his vocation than *placenta prævia.* The location of any portion of the placenta within the cervical zone of the uterus, or in other words, upon uterine tissue ordinarily situated below the presenting part of the fœtus immediately prior to parturition, constitutes this complication. The dangers to be apprehended and the difficulties to be encountered are directly proportioned to the extent that region is invaded. For convenient reference, as well as for intelligent treatment, four varieties should be recognized: central and lateral complete, apparent and concealed partial. Their names sufficiently indicate their nature. Because perfectly contiguous, clear conceptions of each and definite ideas concerning the treatment of their respective types are necessary to remove causeless alarm and inspire proper confidence for every contingency.

Cause and Frequency.—The occasion of this singular situation of the placenta is a deficiency of normal tissue within one or both uterine cornua. Very rarely does this exist idiopathically; primiparæ are almost exempt from its consequent dangers. Until the second pregnancy be past woman's liability to this most serious of misadventures is inappreciable. Its absolute frequency can be determined only with difficulty. Seventy-six physicians state that they never have encountered a case. Fifty-three of these have practiced upon an average a trifle over twenty years. One has been at work fifty years, another forty-nine, a third forty-six, and two forty. On the other hand twenty-five physicians, whose average practice is twenty-two and one-fifth years,

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met twenty cases of complete *placenta prævia*, and thirty-three of partial, or one every tenth year. One reports but a partial in fifty-two years; another, a single complete, in fifty years; and a third, two complete and one partial, in forty years. Combining we observe seventy-eight practitioners found fifty-three cases in one thousand six hundred and twenty-seven years, or one in every thirteen hundred births. The complication is therefore only from one-half to one-third as frequently met as is ordinarily indicated, viz., once in five hundred cases. But let none imagine they will escape this test because of its rarity, or believe the hour of trial far removed. Professor E. Carlton, Jr., of New York city, was called to three in two years; an allopathic physician of Philadelphia, of the last generation, had an equal number in two months. Professor E. B. de Gersdoff's single experience was at the very beginning of his career in Germany, about 1848, while the writer found a central case in the seventh lying-in chamber he ever entered.

Mortality.—The mortality generally attending *placenta prævia* is sufficient to appal the stoutest heart, and although a very considerable portion is avoidable, the remaining dangers may well cause serious concern. In the ninety cases of every variety reported to me eight mothers were lost and thirty-two children. Fifty-seven partial cost the lives of one mother and eleven children. The immediate cause of the woman's death was adherent placenta. The experienced gentleman who removed it stated that its fibres seemed almost interwoven with those of the uterine tissue, that only with the utmost difficulty could the fingers be insinuated between the two structures, and that whatever was taken away came in a fragmentary condition. A constant dribbling from the overlapping placental border prompted the operation. (Premature labor had been induced at the eighth month because all motion had ceased.) Regarding the other stillborn children it should be noted that one was delivered at seven months and four at six; that in one case podalic version was employed; and that in another the attending *regular* physician seemed not to understand the situation, making no attempt to hasten labor or arrest the hæmorrhage until counsel arrived six hours after the first gush of blood. The thirty-three cases of complete *placenta*

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prævia cost seven mothers and twenty-one children, including two miscarriages at four months and two women undelivered. One of these last having nearly attained the climacteric was supposed to be suffering from menorrhagia, and when the family physician arrived (he had not seen her for many months), she was nearly exsanguinated. The other flowed heavily several hours while her attendant persisted in sleeping upon a sofa in an adjoining room. When he awoke to a realization of the situation he sent for counsel, but death anticipated its coming.

Of the five other women who died, one was watched very carefully twelve hours by two "regular" physicians, who could make nothing of the case. Additional aid was then summoned, the placenta immediately perforated and the presenting part allowed to descend, arresting the hæmorrhage inside of five minutes. Labor now progressed rapidly, and in half an hour delivery was accomplished; yet the mother survived but a few minutes. Another was nearly exhausted upon the reporter's arrival, and although a living child was at once delivered with the forceps, she immediately sank from loss of blood. The third was safely delivered, but in a few minutes severe vomiting occurred, followed by uterine relaxation and hæmorrhage. Familiar instrumentalities secured contraction of the womb, but persistence of the cause renewed the difficulty until the patient sank in death. During her entire life she had suffered severely from similar attacks, that were controlled only with extreme difficulty. No anæsthetic was employed, though turning was resorted to, whereby the child was saved. The other two women died suddenly from heart clots within two hours of delivery. In the one case a dead child was born after considerable hæmorrhage; in the other, a living though asphyxiated child, after slight hæmorrhage. Podalic version was resorted to with the latter.

Of the twenty-nine children delivered at or near term, sixteen entered the world most properly, of whom seven were dead and nine living. The other thirteen were turned, but only three survived. This increased mortality is due simply to the unfavorable character of the labors. Infrequent or inefficient pains, extraordinary rigidity of the cervix, exhaustion or discourage-

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ment of the mother, one or all of these at once necessitates the operation and renders its result problematical.

General Causes of Mortality.—The causes of death attending this complication are avoidable and unavoidable. Among the former may be cited (perhaps in the order of frequency and importance) failure to recognize the existing condition, delay in summoning counsel, dilatory or inefficient measures of relief, and rarely overmuch treatment. Among the latter are hæmorrhage during the non-viability of the fœtus, adherence of the placenta and other peculiarities of the mother, anatomical or constitutional, in no manner dependent upon the accident or its cause. The first class secures thrice the victims of the second. Very rarely must the mother be sacrificed. A parental loss of from twenty to thirty-three per cent., and an infantile of from fifty to seventy-five per cent., is inexcusable.

Diagnosis.—Ample directions for the diagnosis of placenta prævia are to be found in every obstetric textbook. Its presence should be strongly suspected in every pregnancy attended with hæmorrhage, unless there be certain proof of its absence.

The Problem.—Though few and simple, the difficulties encountered in placenta prævia, apparently few accoucheurs understand their nature. They are less numerous and less serious in partial than in complete, and indeed in certain cases are absolutely nil. To deliver without jeopardy to the mother a living child when the natural passage is occluded by an obstacle whose direct removal would destroy that life and seriously imperil the safety of the parent, is an embarrassing problem demanding instant solution. Nature unassisted cannot perform the task. Dilatation opens countless vessels, whence flows the life-blood of each. Mechanical difficulties require mechanical remedies; to them alone can we look for support and safety.

Time of Interference.—But when shall this assistance be rendered? Not necessarily when the existence of the complication is first discovered, for in a large proportion of cases child-life would inevitably and causelessly be sacrificed, but *rather* at as *late* an hour as possible, *provided* the mother's safety be not jeopardized and fœtal life be not extinct. Among the indications for immediate action may be specified the commencement of labor,

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the death of the fœtus, the second considerable hæmorrhage, and, when the flow is nearly continuous, the first indications of material debility. The general obstetric maxim,—save the mother at all hazards, the child if possible, applies nowhere more pertinently than here.

Medicinal Treatment.—Concerning the use of medicaments for hæmorrhage prior to the inception of labor I must confess that, while I regard tinctures and low dilutions as my right hand, and 30ths and 200ths as my left, and would be correspondingly crippled were either debarred, I have not the slightest confidence in their efficacy, for the condition is not pathological. Yet a prescription will be expected. Administer then such drugs in such forms as experience or observation has taught will act most promptly and most efficiently as an astringent upon the bleeding vessels. Arnica montana, Belladonna, Chamomilla, China, Crocus sativus, Helonias dioica, Ipecacuanha, Millefolium, Pulsatilla nigricans, Sabina, Secale cornutum, Viburnum, and Hamamelis Virginica, in various attenuations, from the tincture to the 30th, have been reported as efficacious. I incline to the last mentioned. Symptoms resulting from the loss of blood should of course be treated by their similia. So generous a diet will be given as the condition of the patient will permit. Above all things else stands Murdoch's liquid food.

Mechanical Treatment of Complete.—An accoucheur who has diagnosed this complication, and decided upon the present moment for action, should purpose the immediate emptying of the uterus without loss of blood. The measure of success attained will depend chiefly upon the operator's expertness, and next upon available implements. The steps to be taken vary with the existing conditions.

Os Dilated.—1st. If the os be fully dilated and the pains vigorous and regular, the head will generally be found distending the placenta. It remains for the physician, then, simply to attempt perforation. If the obstruction is central he will, he *must* succeed, rending a sufficient passage for the head at once to engage and thereby stop all hæmorrhage. If it is lateral his hand may slip nearly or quite to the edge of the placenta, when perchance the membrane only will be ruptured. Should this point be near

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the edge of the os he would merely crowd the placenta to one side, permitting the head to descend promptly, but if the distance should be considerable it would be necessary to turn.

Os Dilated, but Pains Inefficient.—2d. If the pains are weak and inefficient, or absent, or if the presentation is abnormal (dilatation being accomplished), he will perforate and turn, remembering, as he passes his hand through the placenta, *instantly* to carry it up such a distance that the forearm will serve as a vaginal tampon. Then he can arrange matters at his leisure.

Os Dilatable.—3d. If the os is simply dilatable, admitting the hand, though with difficulty, whatever be the character of attendant contractions he will perforate and bring down the feet, for additional hæmorrhage *must not* be permitted.

Os Undilatable.—4th. If the os is undilatable, forcible distension is requisite to delivery. He realizes the safe accomplishment of this will tax every energy and every resource to the utmost. His heart's desire will be to possess a wedge capable of opening simultaneously a placental passage and uterine without spilling either blood or the amniotic fluid. If he is the fortunate possessor of a Hobb's dilator he will be satisfied. Passing a tightly plugged metallic female catheter or other convenient blunt instrument under cover of his index finger through the cervix to the placenta, he will puncture therewith and immediately withdraw it, inserting the finger as a tampon. Next with his left hand (for the superior cunning of the right renders its use within the vagina *indispensable*) he will pass the staff of the dilator up whence the perforator had just been removed, and then by a skilful movement, more readily imagined than described, substitute it for the finger, directing at the proper instant his assistant to commence inflation. Of course for an instant there will be a certain expenditure of blood and water, but the amount need be but trifling. Now he may quietly rest, maintaining everywhile gentle traction upon the lower extremity of the staff, until the index shows sufficient dilatation, when the hand must be passed into the vagina. The dilator is allowed slowly to collapse, and is withdrawn, while the forearm instantly takes its place as a tampon, permitting the child to be turned and delivered at convenience. Success depends upon those two operations, in other

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words, upon the coolness and skill of the accoucheur at those single instants.

Preliminary and Substitutive Treatment.—Should the uterine orifice be closed so tightly as to exclude the finger, he would first use Molesworth's dilator or other suitable device, as a sponge tent, snugly tamponed to prevent extension. This latter dilator might answer tolerably well in place of Hobbs's for the general complication, but the largest size should be inserted immediately after using the smallest required, that no more changes may be made than necessary. Should he be destitute of all such apparatus he must extemporize as best he may from material at hand. In cities and large towns the nearest apothecary will furnish an unlimited supply of capots, whose use is illustrated hereafter; in the country the poultry yard must be despoiled. The crops of two or three fowl, prematurely sacrificed for the benefit of womankind, and thoroughly cleansed and disinfected with carbolic acid or potassic permanganate (essential to every buggy case) would prove far more convenient and manageable than cotton or cloth, or even sponge tents. Still, each physician must select the best conveniences, and use them as wisely as possible, ever remembering he should not permit the slightest hæmorrhage.

Treatment of Partial.—The general principles which should control the management of complete placenta prævia govern equally that of partial. Their application is less perplexing, however, as the most serious condition does not obtain: hæmorrhage only is to be encountered. Nature generally *can* accomplish her work unaided, yet none should presume upon her energies. In the concealed variety, revealed only by slight shows and a placental edge nearly or quite at finger's length from the os, interference other than medicinal for the purpose of expediting matters *may* be unnecessary. Should the cervical region be farther invaded, more active measures may be required. If the os is dilated or dilatable *and* the pains vigorous the membranes should at once be ruptured; if they are weak and inefficient two courses may be resorted to,—instrumental and manual delivery. I have found such unfamiliarity with forceps among practitioners of more than a quarter century's experience, that

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I dare not recommend the former—the less in proportion as the placenta overlaps the os. Turning at the hands of most physicians is far safer. When the os is undilatable, mechanical measures must be resorted to. The following device is reported to have restrained *all* hæmorrhage; it was successful, for both parent and child survived with unimpaired powers. Three rubber capots were drawn successively over a male elastic catheter and their open ends tightly tied midway its length. At intervals of an inch pieces of string were fastened very loose around them, so that when they were inflated with water by means of a Davidson's syringe, corrugation was manifested. Thus they were retained in the os until advancing labor removed all tension and all need of a tampon.

It is noteworthy that none reporting details of partial cases attempted to separate the placenta from the cervical margin. In certain cases I think that measure *might* safely and advantageously be employed.

General Principles.—Two lessons of wellnigh universal application have been deeply impressed by my year's investigations. 1st. Whatever be the line of treatment adopted in any given case, "external manipulation" is an indispensable adjunct. In every case the contracting uterus must be assisted, guided, and closely followed up until all its contents have been expelled. Even then extremest vigilance should not be relaxed until at least two hours have elapsed. Such ministrations, suggested by common sense and a slight knowledge of mechanics, I have pursued almost from the beginning of my professional career, but invaluable suggestions have been received from Paul F. Mundé's article on this subject in the current volume of his American *Journal of Obstetrics*, a periodical which should be found upon the table of every accoucheur. 2d. Beware of Ergot, *especially in placenta prævia!* Mundé says, in the article above referred to, its "well-known dangers should *absolutely* prohibit its use at any time between the rupture of the membranes and the birth of the presenting part," and Henry J. Garrigues remarks in the same number: "*Ergot ought never to be given during labor.* I use this drug in every confinement, but not before the placenta has been expelled." My own practice corresponds with

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that of the latter gentleman, though I believe that combinations of circumstances and conditions do occur which necessitate its use. They are very, very rare, however, and obtain no more frequently in placenta prævia than elsewhere.

Prognosis.—From the facts above presented it follows that when an accoucheur is asked the result in any case of partial placenta prævia he should reply (*provided* he is possessed of a fair degree of common sense and nerve): Probable safety of mother with possible loss of child; and in complete: Possible loss of mother with favorable chances for child. The practical bearing of this statement upon ecclesiastical complications likely to arise requires but allusion.

Authorities.—My conclusions have been based upon communications received from more than a hundred members of this Institute, and have been but slightly modified either by conversations with other members, and with allopathic friends, or by a perusal of the literature of both schools.

NOTE.—Since writing the above I have received reports of seven cases of central placenta prævia, involving the death of two mothers. To the first a lady physician was summoned, who properly diagnosed the case and requested counsel. The family physician was summoned, but could discover nothing alarming, and remarked, "*We* will wait for nature." The lady promptly resigned the case after stating the urgency of action to both parties. He permitted constant and unrestrained flowing to fainting, and at the end of twenty-four hours delivered a dead child from a breathless woman. In the second case the physician, who had already attended one complete and one partial successfully, unaccountably waited hours for counsel, then drew off the waters with a catheter, and pushing aside the placenta applied forceps; but the woman expired before the head was delivered. Of the five remaining children only one was saved, hæmorrhage having obtained in each case three or more weeks. Moreover one was a consultation case relinquished to the reporter twenty-four hours after the inception of labor. In one instance pelvic cellulitis followed tearing off the placenta; this was delivered twenty minutes after that operation, the child an hour later. Discovery of its death when perforating the membranes prompted the procedure. Seven partial cases were also reported, involving a loss of two children, one because of pelvic malformation.

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CÆSAREAN SECTION.

By S. S. Lungren, M.D., Toledo, O.

The subject of the Cæsarean section has occupied the attention of accoucheurs and surgeons of the present day, as in the past, with the most diverse opinions as to the dangers and benefits to be derived from its performance. Perhaps there is no other operation which has provoked so much discussion, without arriving at a satisfactory conclusion. The dread of performing it, when every step seems so terrible and bloody, would rather invite a resort to the crotchet and the perforator, when the injury, although concealed, is oftentimes, in a narrow pelvis, much greater to the mother, than by the operation under consideration. To the child, of course, it is death in every instance. I propose briefly to compare the results of Cæsarean section with the application of the forceps at the pelvic brim in a narrow pelvis. I also insist that *time* is the most important element, "and that delays are dangerous, and almost always fatal."

From an admirable paper by Dr. Harold Williams, of Boston, published in the January (1879) number of the *American Journal of Obstetrics*, some startling statistics have been collected, having such a bearing on this subject that they will be quoted at some length. As shown by the paper referred to: In a comparison between the Cæsarean section and the high forceps operation or delivery, by applying the forceps to the head above the brim of the pelvis, that out of one hundred and twenty-five (125) cases of Cæsarean section operated upon in all stages of labor, 51.2 per cent. of the mothers lived, and in the high forceps cases 60.52 per cent. of the mothers recovered; while as regards the children 82.3 per cent. were saved by the Cæsarean section, against 38.18 per cent. in the high forceps cases. When we come

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to compare cases as nearly alike as possible, and when the *duration of labor* is taken as the fairest standard, we find that when the duration of labor was less than forty hours, and the liquor amnii had escaped not less than thirty hours, that in Cæsarean section 34.8 per cent. of the mothers died; and by the high forceps operation 31.48 per cent. of the mothers died. Of the children 35 lived after Cæsarean section, out of 44 cases operated upon; and under high forceps delivery only 20 children were saved out of 54 cases. Comparing cases of Cæsarean section with high forceps operation, where the labor was less than 40 hours, and without *serious complications*, we find that Cæsarean section gives 73.69 per cent. of recoveries of the mothers, and 91 per cent. of the children, against 69 per cent. of the mothers, and 41.67 per cent. of the children saved by the old and time-honored high forceps operations; 16 only of these being timely. Lastly, in labors of 24 hours or less, there were by the Cæsarean section, 79.4 per cent. of maternal, and 92.6 per cent. of children saved; whereas the high forceps operation under similar circumstances gives 41.4 per cent. of children and 69.7 per cent. of maternal recoveries. Or in other words the Cæsarean section is 10 per cent. more favorable when made early to the mother, and 51 per cent. more favorable to the child than the high forceps operation. The deductions from these statistics prove: 1st, that when Cæsarean section is done in 24 hours after the commencement of labor it is 6 per cent. more favorable than when delayed to 40 hours, without complication, and it seems equally true that when the operation is performed still earlier in labor, still more favorable results might be hoped for. The most favorable time is during the first stage. 2d. That the high forceps operation should be undertaken with the greatest hesitation, inasmuch as its results to the mother are more fatal than those of Cæsarean section, while the prognosis as to the child is far better in the latter.

3d. When the question arises as to what operation will give the best chances to both mother and child, the choice must lie between Cæsarean section and turning.

4th. Cæsarean section seems especially called for in those cases of labor, complicated with ovarian tumors, which can neither

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be pushed out of the way nor punctured, since it has been found that 50 per cent. of women died in such cases when craniotomy was employed; whereas we find that Cæsarean section gives nearly 80 per cent of recoveries of the mothers, and saving 92 per cent. of the children.

I shall now cite two extreme cases taken from the paper of Dr. R. P. Harris, describing thirteen cases of Cæsarean section operated upon in the State of New York, to compare the advantages and disadvantages of the early and late operation.

As an instance of the power of nature to sustain life after the early operation, a case is related by Dr. E. D. Bassett, of Nassau, Rensselaer County, N. Y., which occurred January 29th, 1822. A quadroon servant, aged 14, performed the Cæsarean section upon herself, by an L shaped incision, while lying upon a snow-bank. She had delivered herself of a fœtus *per vias naturales*, which she had buried in the snow. And a second one was protruding through the abdominal wound. He removed the fœtus, dressed the wound, and she recovered in twenty days, and was alive and well six years after. The girl recovered because the operation was performed *early*, the uterus was not exhausted by futile attempts at delivery, and was in fit condition to bear the incision; the risk not being increased by prolonged uterine action, and consequent exhaustion. Compare this case with one operated upon at East Solon, Cortland County, N. Y., June 11th, 1845, by the late Professor Azariah B. Shipman. The necessity of the operation was caused by a fibrous tumor which forced the cervix uteri above the superior strait, and to the left side, so that version, the use of forceps, and craniotomy were impossible. Mrs. S. K., the patient, was in labor at intervals for *two weeks* before Dr. S—— saw her. Three accoucheurs were in attendance, and the amniotic fluid had been drawn off for three days. The patient was now weak and exhausted, pulse 120, but begged for the operation.

Now see in what condition the uterus was found upon opening the abdomen.

"Of a dark chocolate color, and parted before the knife as if partially decomposed." Child dead. Woman died of shock and exhaustion an hour after the operation. Similar conditions

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have been found in other operations in delayed labor. Dr. Ludwig Winckel, who has had a larger experience in these operations than most others, speaking of this class of cases, says: "There is no attempt at repair, and actual sloughing and loss of substance occurs, the uterine wound gaping widely, when death has taken place many days after the operation." What is the cause of this condition of the womb?

To understand this question fully, we must study the cause of and beginning of labor. Nature has her analogies throughout animate and inanimate creation. The ripening of the human fœtus may be likened to what occurs in the vegetable domain.

Flint has shown that "towards the end of pregnancy fatty degeneration commences in the decidua vera, and that portion of the placenta which is attached to the uterus. There is a gradual separation of the outer membrane, so that the contents of the uterus gradually lose their anatomical connections with the mother. When this change has progressed to a certain extent the uterus begins to contract. The pear is now ripe; each contraction then separates the membranes more and more; the most dependent part pressing upon the os internum, and the subsequent contractions are probably due to reflex action. The first 'pain' is induced by the presence of the fœtus, and its membranes, as foreign bodies; a mechanism similar to that which obtains when premature labor has been brought on by separation of the membranes. As labor advances the inference is that fatty degeneration and disintegration of the muscular fibre cells begins to take place in the uterus, commencing with, and continuing during and after labor in the normal accouchement. Should there be pelvic obstruction no matter from what cause, the breaking down of the muscular structure of the uterus goes on under the continual efforts at expulsion, for there is no attempts at repair. The pains, which had been regular and powerful, become irregular in force and recurrence. For a period they may become more rapid, and then return less frequently, and with less effect; growing weaker until the characteristic bearing-down effort is lost; and with equal suffering, we have the loud outcry and slight force of the first stage." Other symptoms supervene after the breakdown of the uterine structure. "Shivering becomes

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so severe as to resemble slight convulsions. Vomiting becomes frequent and distressing, and green or bilious matters are ejected. The patient is restless, throwing her arms about, and repeatedly changing her position. The skin is hot, whether moist or dry, the pulse rises from one hundred to one hundred and forty. The tongue is dry, loaded and furred with sordes. The mind is disturbed, fearful, and despondent. The vagina is hot, and with the os uteri tender to the touch. The bland mucous discharge becomes yellow or brownish in color, and sometimes acrid and fetid. Now should not this case be relieved? It goes on from bad to worse, all the symptoms are aggravated, and new and most formidable ones are added. The vomiting becomes more frequent, and the matters ejected are dark-colored. The abdomen becomes tender, the jactitation and restlessness ungovernable, the pulse rapid and feeble, the skin covered with cold and clammy sweat, the tongue brown and dry, the patient falls into a state of semi-stupor, with low muttering delirium, and ultimately death closes the melancholy scene. Such is the graphic picture given by one of the ablest writers in midwifery. Compare this description with the case operated upon by Dr. Shipman, and the result could have been foreseen. That woman could not recover, for the *time* had passed for nature to make the attempt. And instead of the Cæsarean section being the *dernier ressort*, it should have been the first."

Now let me insist that *time* is the most important element in all obstetric *operations*. Let the accoucheur be on the alert, ready and willing to perform any operation that the exigencies of the case demands and his judgment commends, for the good of his patient; and when that judgment is formed, let him not hesitate, remembering that he can gain nothing by waiting if his opinion of the case is correctly formed, since every hour after the second stage of delayed labor has once commenced, more especially if the amniotic fluid has drained away, adds in an accelerated ratio to the danger to both mother and child.

Contrasting craniotomy in a very contracted pelvis, with the Cæsarean section upon the same person, I would call attention to the celebrated case of Mrs. Reybold, of Philadelphia, whose pelvis was two inches in the antero-posterior diameter at the

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superior strait, and who was taken in labor at one o'clock A.M., Tuesday, June 14th, 1831. She was attended by Dr. Charles D. Meigs, that kind and learned physician, whose lectures on obstetrics during the winters of 1848 to 1850, it was my privilege to listen to, at the Jefferson Medical College. After several consultations with the most eminent surgeons and accoucheurs of the time, Doctors Physick, Hewson, Rhea, Barton, and James being among the number, occupying a period of sixty-four hours since the commencement of labor, Dr. Meigs decided to deliver by craniotomy, the child being alive up to one hour before. His efforts commenced at 5 P.M. on Thursday, and were continued with but little intermission (the patient entirely exhausted and begging in the interim to be let alone to die), until 2 A.M. Saturday, when he was fortunate enough to deliver what remained of the fœtus, "which was soft and putrid. The cord was black, as also the placenta, the latter being so offensive that it was scarcely possible to endure it during the requisite handling." Just two years afterward she was delivered again by craniotomy; she became pregnant again, supposed to be in 1835 (date not stated); the child this time presented by the breech, rendering delivery impossible except by the Cæsarean section; a method which should *in the first case* have been adopted. This operation was performed by Professor Gibson of the University of Pennsylvania; she made a good recovery and had a living child. She was taken again in labor at 5 A.M., November 5th, 1837, and at 9 A.M. the Cæsarean section was performed with the result of again saving both mother and child. This case and the one I am about to relate, are the only cases in this country, to my knowledge, where the woman has been twice successfully operated upon, and the life of mother and child preserved.

The subject, Marie Keyser, aged 29, when first operated upon, is a Bavarian by birth, the wife of a tailor. Youngest of six children. She was affected by rickets when she was a year and a half old; her father died of phthisis at that time. She was placed in a hospital and kept in the recumbent position, as she avers, until she was two and a half years of age. She married at twenty-one. Has been pregnant five times. The first time

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the fœtus died *in utero*, and was expelled a week afterwards. Twice she had abortions at three and four months respectively; once produced by the physician in attendance, once from some cause unknown. About the middle of March, 1875, I was consulted by the patient and requested to take charge of her case, in her then expected confinement. I had attended her some years previously for uterine disorder, and then noticed a malformation of the pelvis. The ossa pubis was wide and inclined backwards, while the coccyx curved forward more than usual. The concavity of the sacrum was increased below, while its promontory was projected forward so much at the superior strait that the diameter was not more than two to two and a quarter inches. This was not discovered at this time. Believing that delivery could be accomplished through the contracted opening of the inferior strait dilatation was attempted with Molesworth's dilator. It was discovered at this juncture that the greatest deformity was at the superior strait, where the promontory of the sacrum feeling like the head of the child projected into the middle of the excavation. The patient at this moment taking advice of friends, who induced her to believe that "it would be all right and help itself into the world" when the full term of her gestation was completed, declined to allow any further operative proceedings had we been so disposed. On Saturday, May 8th, 1875, was called at 10 A.M., found slight labor pains. A consultation was called of several medical friends at 3 P.M.; we then found the pains coming on at intervals of ten minutes, the bag of waters dilating the os uteri to the extent of about one inch (it had remained patulous since the previous dilatation), auscultation was resorted to and the child was found to be alive. The placenta was supposed to be attached anteriorly. The patient being laid upon a table thickly covered with blankets, Chloroform was given, and a final examination was made under the relaxing influence of that agent, so as to be absolutely certain that there had been no mistake in any of the measurements of the pelvis taken previously, the whole hand being introdued into the vagina for that purpose, and also, as the pains were quite strong, to discover the exact relations of the child's head to the contracted opening, and whether embryotomy could be safely performed.

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The question now resolved itself into these two points, embryotomy or the Cæsarean section. Taking into consideration the extremely contracted opening, the risk from embryotomy was very great to the mother; one life would of necessity be sacrificed, perhaps both. The Cæsarian section gave the possibility of life to both. The latter alternative was adopted. The description of the operation was given in a former paper. Her child, delivered at that time, is now a bright, healthy girl of five summers. The second operation, which occurred May 22d, 1880, differs but little from the first. About three hours after labor pains were well established, the os uteri being dilated to the size of a silver quarter of a dollar piece, the patient being well under the influence of Chloroform, and assisted by Drs. Goodwin, Barlow, Parker, and Gavitt, the operation was commenced by an incision through the integument reaching from a point just below the umbilicus to within one and one-half inches of the symphysis pubis. The wall of the abdomen was found quite thin, and adhesions were suspected at some points between it and the uterus, but none were found upon opening the abdominal cavity. Upon exposing the uterus search was made for the silver sutures placed there five years previously; they were seen under the peritoneum, but without any signs of irritation from their presence.

It was considered best not to remove them, as hæmorrhage might be troublesome from the uterus at that point after closing the abdominal wound. The right ovary resembled in color varicose veins; the left was normal. It was the intention at first to remove both ovaries during the operation, but decided, after mature consideration, that the risk would be lessened and the same result would be accomplished by tying both Fallopian tubes with strong silk ligatures about one inch from the uterus. Compression being made, by an assistant, of the abdominal walls against the uterus, that organ was divided, one inch to the left of the former incision, layer by layer, until the membranes were seen bulging through the opening. At one point the uterus was about one inch in thickness, owing to a small intramural fibroid which lay in the course of the incision; the general thickness was about one-quarter of an inch. As soon as the incision was completed to the extent of six inches, the

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membranes were ruptured downward by a catheter passed through the os uteri, followed by a sponge in a long holder, the child seized by the feet and delivered at once, the cord cut by an assistant. The child was a boy, and cried loudly as soon as delivered. The placenta and membranes were removed, and the uterus siezed with both hands to induce contraction, as the hæmorrhage was great at this moment; it soon lessened, and twelve horse-hair sutures were rapidly introduced. In spite of closing the opening so closely blood welled through. Three of the horse-hair sutures were removed, and silver wire substituted; there was some oozing between the sutures, more marked at the site of the fibroid. After waiting until all flow was apparently stopped, the abdominal wound was closed by interrupted silk sutures, except the two lower ones, which were of iron wire, as some blood still flowed, during uterine contractions, from the wound in the uterus, a fenestrated rubber drainage-tube was introduced, the lowest suture being passed through it. Strips of adhesive plaster twelve inches long retained in position a portion of lint, saturated with carbolic acid one part, linseed oil two parts, and laid lengthwise upon the incision; over all a binder, and the patient then put to bed. She never lost color of the lips or face during the whole time, to any extent, and there was no fever of reaction, as there was no exhaustion. Visited her four hours after the operation; found she had some after-pains and pain in the line of incision; about two ounces of blood had passed by the drainage-tube. Absorbent cotton, saturated with carbolic acid one part, water twenty parts, was laid over the drainage-tube and retained by plaster. Pulse 90; temperature 100°, which was the highest temperature and pulse noted after the operation. The next day it fell to a temperature of 99⅜, pulse 76, and the variation was from 70 to 76 for the pulse, and 99 to 99⅜ for the temperature. There never was a single alarming symptom after the operation. Medicines used were Aconite and Arnica for the first six days, then no medicine. Twenty days after the operation she attended to her household duties, apparently as well as ever. The external wound united by first intention along the whole line, except at the lower angle, where the drainage-tube was inserted; as all blood and serum ceased to

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flow through the tube after the third day, it was removed, and that portion of the incision healed rapidly. As after the former operation, there was not the least odor to the lochial discharge at any time. In every respect she had a better "getting up" than the average case of labor.

It may be of interest to the members of the Institute to give the statistics of the operation in this country up to the present time.

The whole number of cases of the Cæsarean section in the United States is one hundred and thirteen (113), with 49 recoveries. The whole number for North America is 121, with 56 recoveries. There have been 28 early operations, with 21 recoveries, and 23 children out of the 28 were born alive. There were 19 cases in which the sutures were used to close the uterine wound. There have been nine women operated upon twice in America, and seven saved. Mother and children both saved in two instances.

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APPENDIX.

DISCUSSION.

Dr. Spaulding, of Mass.: The paper on Placenta Prævia has been very interesting to me. There is one symptom that I claim as a symptom of placenta prævia that is ordinarily considered an unusual phenomenon, though it appears occasionally under the eye of the obstetrician, and that is the continued menstruation. I claim that these cases, though they are very rare, are sometimes reported. I happened to have one case that was reported that proved to be a case of placenta prævia; the case I will briefly report. The lady did not consult me until the time of her confinement. She told me that she only missed one menstrual period; after that there was an appearance of the menses, as she called them, every month, that is, there was a flow. The way I account for this, as attending placenta prævia, is the fact that there was, during the pregnant condition, at regular or nearly regular intervals, contractions of the uterine walls, occurring especially at the menstrual epoch. These contractions were more severe then than at other times, so much so that I think that is the reason why so many women can say just when the menstrual period would occur, from their uncomfortable feelings during gestation. These contractions start, it may be, a few fibres attached to the placenta; they break their attachment, and we get a slight discharge during the latter months of gestation; they become more and more numerous. That appeared to be the condition of this lady. At last she was confined, at what would have been the seventh menstrual epoch, that is, twelve weeks before the natural termination of gestation, and she was delivered of a living child, which is still living to-day, but it would have been a mercy to humanity if that child had not lived, because he shows in every sense that there was an incomplete development; he is physically and mentally weak. The mother recovered. The labor was not serious. I managed the case simply by rupturing the membranes as soon as I discovered the condition, which was at once, on my first examination. The pains came on and the

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child was delivered naturally. It was a small child, weighing about six pounds. I presume the continued attacks of hæmorrhage and the debility of the mother were the reasons for the child being so small. I bring out this point as an interesting one. I do not know that any one has brought this up, or has given an explanation of it before.

The statement has been made that placenta prævia will not be found in primipara cases. In this last case, I will say, the placenta was in the lateral portion, it was not directly in the centre. The only case I ever had where the central portion of the placenta presented over the os was in a primiparous woman. When I visited her I found her unconscious, and the blood was flowing from the foot of the bed. I immediately inserted my hand into the cavity of the womb by rapidly dilating the os; there was no time to procure an instrument; I did not wait, but went right to work, put in a plug and administered stimulants after having turned the child and delivered it. Of course the child was still-born.

Dr. Edmonds, St. Louis: I wish to ask the indulgence of the members of the Institute for a few moments while I call attention to what I regard as of great importance—it was illustrated by Dr. Walker—that is, upon the management of the cord. You are all aware there has been a great deal of controversy upon the subject of the ligation or non-ligation of the cord. It seems to me that the course indicated by Dr. Walker is a happy compromise between ligation and non-ligation. I have reference to the cutting of the cord and allowing it to empty itself before the ligature is applied. You all understand the old-fashioned way of putting two ligatures; this is done for the purpose of preventing hæmorrhage from the placenta and from the body of the child. Now I regard this matter, though seemingly a small one, as a matter of great importance. I think the failure to ligate the placental end of the cord is a matter of importance. It allows the blood to flow away, and contributes to the contraction of the uterus and the expulsion of the placenta. Allowing the blood to flow away from the fetal end of the cord places it in a good condition for the process of desiccation, or drying away, and without which there frequently occurs, as is known to most of us in our experience, a slow process of decay, sloughing, and fetor of the cord. I think this is a most happy compromise between the two methods of ligation and non-ligation.

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LACERATION OF THE CERVIX UTERI.

By H. F. Biggar, M.D., Cleveland, O.

Cervical lacerations may occur, and may, by the reparative processes of nature, become thoroughly healed and require no service from a surgeon. It is probable that, in giving birth to her first child, every woman suffers a laceration of greater or less size. Where the lesion is slight, and in a position favorable for rapid healing, it may occur and be completely cured, while its existence has never been recognized and perhaps not suspected. In the very soft condition of the cervix at childbirth it would be useless to expect to learn, from examination, whether such lesion had taken place, unless a very profuse hæmorrhage should follow. There are no unusual signs accompanying the existence of one or more rents, even though they should occur of considerable size, by the appearance of which the surgeon is enabled to decide upon the presence of the lesion.

Cervical laceration befalls a patient at the time when her enforced recumbent position during many following days plays a most important part in aiding nature to effect a cure. A lacerated anterior or posterior lip is more likely to heal voluntarily than a laceration in a lateral direction; the former are also of more frequent occurrence. Of course, should the tear in either posterior or anterior lip be very extensive it is liable to give rise to complications which demand surgical interference. Those which readily heal of themselves are slight, and confined to the cervix, being generally in the median line. The pressure given by the walls of the vagina is from a lateral direction, and this pressure, aided by a recumbent posture, is the very condition best suited to the healing of the parts, especially when warm-water injections are used to assist the work, by keeping the parts

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thoroughly cleansed. Should the rent in the anterior lip extend beyond the cervix through the septum, a vesico-vaginal fistula will probably result, which condition will demand its proper treatment. Should a rent in the posterior lip be so extensive as to divide the cervix and extend into the cul-de-sac, and should cellulitis follow this condition, it is probable that this resulting inflammatory state, which is serious in itself, would be an important factor in inducing an intractable retroversion. The lacerations which are backward or forward are therefore those least likely to prove so serious as to come under the eye of a surgeon, and when they do so they are exceptionally severe cases of their class. The lateral lacerations are those which nature seems to work antagonistic toward aggravating them and rendering them worse, just as she most assists in healing those rents which extend in the opposite directions. When the injury is double the effect is more serious than when it is confined to one side. It is easy to comprehend what an irritation is established in the case of a double lateral laceration if the woman attempts an upright position before the parts are healed, and even when the raw surfaces are, to some extent, joined. A standing position allows the heavy uterus to tear them apart, and an erosion of the surfaces causes them to bleed readily. In the existence of the double lateral rent there is a tendency for the inner surfaces to roll down and out between the wounded lips. Where the rent has been so extensive as to cut its way to the vaginal junction or beyond, if the patient assumes an upright position, the everted inner uterine surfaces, pushing down, will cause the posterior lip to catch against the back vaginal wall, while the anterior lip is crowded forward and down the vagina, thus separating the flaps formed by the laceration; the heavy uterus also bears downward at the same time, forcing the flaps even further apart. A condition of this kind, it is readily seen, is necessarily the precursor of numberless dangerous diseases, which may follow sooner or later.

The angle of laceration is the point from which an extensive erosion must start, and in the light of our present knowledge of this condition, we see how frequently the unavoidable appearance, after the condition just described, has been and is mistaken by

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the practitioner for a state of ulceration, or of epithelioma of the cervix. Of course no amount of treatment for ulceration would cure a state like this, and for want of a proper understanding of the true cause of these abnormal appearances the patient must continue to grow worse. Should one suffering from this state of affairs try to describe her condition, she would mention a continual backache, with profuse leucorrhœa, which comes from the cervix, a pain extending down her limbs, inability to stand without suffering, and, as a consequence of all this, a great nervous disturbance.

Sometimes the lesion is confined to one side, although it may be extensive, and a complete laceration. In this condition it is quite as difficult to discover the injury, but the cervix is not so large in appearance as in case of a double laceration, and, as a matter of course, the rolling out of the inner tissues cannot be extensive.

There is another form of cervical laceration which brings in its train all the bad effects the lesion can produce, but of which it is frequently hard to prove the existence. This rent seems to start from within and extend outwards and downwards, without reaching through the thickness of the cervix. It seems as if partial laceration started from the internal os and extended downward on different sides through the inner thick tissues, without penetrating through the vaginal surface of the crown of the cervix, forming seams and folds among the inside membranes. The cervix, during the existence of a lesion of this description, is apt to be a little larger in diameter, and the walls are thinner than is natural, while there is a most profuse and sticky or tough discharge from the everted surfaces. As it is only during the past twenty years that this lesion has received attention, and during these years has been studied by very few among the medical profession, there is much either suspected or taken for granted concerning it which will not bear the close scrutiny of a thorough investigation.

It has been attempted to arrive at certain facts about either the normal or abnormal condition of the uterine functions of women who are suffering from lacerated cervix, and it is found that these discovered facts or bodily conditions fit equally well those women

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who have never suffered from the injury. The fact that over thirty per cent. of the women who had been impregnated, and who had also suffered from some form of uterine disorder, were found also to have lacerated cervix, has been substantiated. This is a very large proportion, and may well give rise to the wonder that such a very frequent injury should have been almost ignored for so many years, for if the given per cent. of women now suffer from this injury, it is only a proper deduction to make that a like number have always similarly suffered. It is a natural thought that a rapid, forced labor is the circumstance to which we must look as the cause of a large number of these lacerations, and such may in the future be proved, but from the figures we have upon the subject we cannot deduce this fact at present. It is but just to say that whatever tables of statistics we have about lacerated cervix are made by a physician of our own country, from his personal practice, but these figures give so little in the way of deciding the most important questions about the injury that, except as they serve to show its effect upon the menstrual function, these tables decide but little about cervical lacerations for us. In cases of abortion, when the parts are so quickly dilated as to cause a discharge of the contents of the uterus before the full time, it is natural to suppose that a lacerated cervix must be the certain consequence.

By referring carefully to the early history of women who have this injury, that is, their history as to the period of menstruation being normal or otherwise, as regards regularity, pain, or quantity, it demonstrates that no existing condition in early life points toward a liability to this injury in the future. As regards station in life, no class of women are more liable to this accident than another. Perhaps the use of instruments in delivery is more frequent among the poorer classes than among the wealthy, and where forceps are permitted there the per cent. of women who suffer the accident is greatest. Where the lesion has taken place it is the rule that sterility is the result. The menstrual flow is interfered with in different ways and degrees where there is cervical lacerations, and cellulitis is the most frequent complication in connection with or as a consequence of its existence. It requires great care in diagnosing this injury, and one is con-

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stantly taught much by experience. Where the lesion is known to exist treatment is called for, because even if, at the present time, no active harm is being done apparently, the time will come when such condition is seen to be the foundation of the serious trouble which is its sure follower. Although the surfaces may to all appearances be healed, treatment is necessary if the uterus is still enlarged, or if the patient is suffering from a greater or less degree of pain about the seat of disease. Future observation has much to determine in regard to cervical lacerations; indeed it would seem that the many questions concerning its beginning, nature, course, and ending, which are still entirely unanswered, are much more numerous than those questions which have already had a decisive reply. It is satisfactory to know that as regards the best mode of treatment for the lesion there is no doubt. In fact, those questions concerning whose answer the doubt still exists for want of proof, are those questions which more nearly relate to the prevention than the cure of the disease under discussion. The operation of finally joining the flaps, which in being torn apart constitute the injury, should not be undertaken until all soreness upon pressure is removed, and the uterus has been reduced by proper treatment to a lesser weight. While the uterus is of such great weight it will drag on the surrounding tissues resting upon the floor of the pelvis, and while in this condition can but keep up a great congestion among the cellular tissues as well as in itself. This congestion must be relieved, and the overcharged vessels must regain their normal tone and power to act. The great downward pressure must be removed by lifting the uterus from the pelvic floor and retaining it in the best position by a proper pessary. All suitable preparatory treatment will aid in restoring the impaired circulation through all the affected parts. If the condition of the surfaces is that of bleeding readily, and of being covered with granulations, then its peculiar phase must be met with its own especial needs. Where the mucous follicles have passed into a state of cystic degeneration, the cysts must be emptied by being punctured and treated with the proper remedies until this condition entirely disappears. The different modes of attaining the state which must be reached before an operation is safe in any degree, might be enlarged upon as to remedies used and under what circum-

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stances they should be used, as to mechanical aids, how used, and when used; but cases differ so widely that special rules cannot be given unless in reference to special cases. When an operation is to be performed there must be absolutely no feeling of soreness when the parts are touched, and the lacerated parts must have been reduced as far as possible to their normal size and appearance. To achieve this result must presuppose on the surgeon's part a very full yet nice understanding of the best mode and the best instruments of which to make use toward the accomplishment of his purpose. As to position during the operation, it is generally best to place the patient upon the left side and to use a speculum, which, by drawing back the perinæum, will bring the parts into view; it is possible in some cases to perform the operation on the back by drawing the uterus down and replacing after the operation. The left side is preferable because there is less rolling out of the tissues, and it is also safer, since if the rent has been extensive enough to have caused cellulitis at the time of the injury it must of necessity have left a shortened broad ligament, which, in case of an operation upon the back, must alone bear the force of the traction, and will probably cause a fresh attack of cellulitis. In some cases the uterine tourniquet is a necessary instrument and prevents hæmorrhage, since, when in position, it surrounds and clasps closely the cervix at a point just below the vaginal junction. Sometimes a hot-water vaginal injection, if given in a large quantity just before the operation, will prevent too severe a hæmorrhage. In the case of a double laceration, the flaps being fully separated, they must be thoroughly denuded from anterior lip to posterior lip, taking care to leave a broad tract of skin in the centre, which is to form the new uterine canal. The shape of the portion which is left undenuded must be of similar shape on each side, and must grow wider from the internal os toward the edge of the divided portion of the cervix. When healed the canal will be of uniform diameter, and it is made wider at the outer edge, at the time of operation, to make allowance for the increased hypertrophy which exists at the outer edges of the flaps. The surfaces can be freshened either by scissors or by scalpel. The tissues at the outer angles of the fissure at the vaginal junction should be very superficially removed. The surfaces to be joined should be of

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the same size and shape, and should be approximated with great accuracy, for the best result is obtained with union by the first intention; if there be a projecting edge left to heal by granulation there is danger of a cicatrix and some contraction, which might be almost as disastrous in the end as the first difficulty. There are operations necessary in cases of laceration on one side only, in cases of bifid laceration, and in cases of stellate laceration of the cervix. When a surgeon once understands the lesion under discussion he can decide almost at a glance upon the proper course to follow in any individual case which may be brought to him. The minor points to be observed as fitting to special states and kinds of laceration might be almost endlessly enlarged upon. The after-treatment of all cases is similar, and consists chiefly in confining the patient to rest in a horizontal position for at least fourteen days. The diet in quantity and in quality should be suitable for a person remaining in bed, and a catheter should be used. After the third day a tepid water injection should be given daily, if the quantity of the discharge seems to demand it. The sutures can generally be removed the seventh day, and great care must be exercised in the withdrawal of them. The uterus should be left anteverted after the operation, since if in any other position it will crowd down lower in the vagina when the patient stands on her feet, and there will be danger of a return of the original trouble. If a mechanical support has been previously used, and after a thorough restoration to health is still needed, a smaller one will be found best to employ in order to assist the vagina to return to its natural size. Should a lacerated perinæum exist in connection with lacerated cervix, it should be operated upon after the cure of the latter injury. The idea has been advanced by an American physician, who has given much attention and time to investigating the lesion, that a lacerated cervix is the true condition where a so-called elongated neck or hypertrophied cervix are said to exist; further, he holds that there can exist no occasion to amputate the cervix entirely or partially, except in case of malignant disease, because only a lacerated cervix can give rise to the described condition, and therefore an operation for that injury is alone called for. At all events it is a subject for fruitful and most interesting investigation, and it is almost impossible to speak of it at greater length than it deserves.

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INFLUENCE OF HOMŒOPATHIC TREATMENT UPON THE DEVELOPMENT OF OVARIAN CYSTS.

By B. Frank Betts, M.D., Philadelphia, Pa.

A few months ago I directed circulars to be sent to a number of homœopathic physicians in different parts of the country, requesting them to ascertain, as far as possible, which school of medical practice their patients suffering from ovarian tumors habitually employed when sick previous to the first recognition of these growths, and especially as to the kind of treatment habitually administered to them when sick during childhood. My object in asking for this information is to present to the Institute, at some future time, the history of a large number of cases of ovarian tumors, from which we may ascertain whether persons accustomed to homœopathic treatment from infancy are less liable to have ovarian cysts develop than those who have not so employed it.

In the embryo the ovaries are formed from a collection of molecules, into which solid masses of cells project from the surface towards the interior. By an aggregation of these cells upon the sides of the masses a hollow space is formed within, giving the mass the appearance of a cylinder or tube. These are known as Pflüger's tubules. They speedily become constricted into segments, and present somewhat the appearance of a rosary, or a chain made up of several links. Each one of these links or segments develops into a Graafian follicle. Whilst the Graafian follicles are being formed in this way the connective tissue stroma or framework of the ovary has developed, so that the ovary at birth is composed of stroma and follicles.

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When a morbific influence prevents the normal physiological process by which these histological elements are formed, we have, according to pathological investigations, the development of ovarian cysts.

Whilst it is possible for the ovary to be so thickly covered by an organized exudate resulting from inflammatory processes as to prevent the rupture of the follicles as they mature in the adult, and thus lead to such a distension of them as to form large cysts, in a majority of instances the cysts commence developing in the embryonic tissue of Pflüger's tubules; therefore they must either date back to fetal life, or else there is a constant development of embryonic elements during adolescence from which they are formed. The fact that ovarian cysts are found in infancy during post-mortem examinations proves that they do sometimes originate at the former period, but, in either instance, is it not likely that homœopathic treatment will, in many cases, prevent the growth of these tumors, even when it is instituted for the purpose of curing some affection that may appear to have no connection with the ovaries, or without one having any knowledge of the pathological condition developed within them? There is no other way to prove this than by comparing the history of a large number of cases. That we may obtain this history I have prepared blanks to be furnished to physicians, upon which may be recorded: 1st. The patient's name and address. 2d. The variety of the tumor—whether solid or cystic. 3d. The age at which it was first recognized. 4th. The treatment of the tumor—whether by operation or otherwise. 5th. The result of treatment. 6th. And whether or not the patient had homœopathic treatment, previous to the first recognition of the tumor or during childhood.

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HOW DO MEDICINES ACT ON THE GENERATIVE ORGANS OF WOMEN?

By E. M. Hale, M.D., Chicago, Ill.

Before entering into a consideration of the subject of this paper, it may be well to define the present condition of our physiological knowledge concerning the seat of sexual innervation and emotion.

It was once supposed that the cerebellum was the seat and centre of sexual innervation; but this theory has been abandoned.

Ferrier (*Functions of the Brain*) observed that the sexual impulse was manifested after the removal of the occipital lobes. He says (page 198): "It would seem, therefore, to have been caused by central irritation, and the conditions were such as to excite by inflammatory irritation the centres of sexual feeling, supposing them to be in immediate contiguity to the line of section of the occipital lobes.

"The organic wants which form the basis of the sexual appetite centre round a special form of tactile sensation, and this may be supposed to have its centre in close relation to the hippocampal region. Further, as is well known, one of the most powerful excitants of the sexual appetite in the lower animals is a special sexual odor, and though in man the excitation of sexual appetite by smell is not so apparent, yet it is considered by some, and with great probability, that the fondness for certain odors, especially musk, its congeners and derivatives, is closely allied to the erotic instinct. A region, therefore, in close relation to the centres of smell and tactile sensation might be regarded as the probable seat of the sensations forming the basis of the sex-

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ual appetite. The occipito-temporal convolutions, or those connecting the lower and inner part of the temporo-sphenoidal with the occipital lobe, would fulfil these indications, and at the same time are so situated as to have been irritated by the inflammatory processes set up by the section of the occipital lobes."

In another place Ferrier says (page 262): "The sexual appetite, though springing from the wants of certain glandular structures, centres itself round a certain tactile sensation, which is the reflex key to the gratification of the physiological demand for functional exercise on the part of these organs. The sexual appetite appears only with the development of the generative glands. Its appearance induces considerable perturbation of the other organic functions, and expresses itself subjectively at first, chiefly in the form of emotional excitability, or in obscure longings, morbid desires, or hysterical outbursts. Long before the link between a definite sensation and a definite action for its realization has been established in consciousness, the generative glands may gratify themselves reflexly during sleep, the period, *par excellence*, of reflex excitability.

"As morbid irritation of the generative organs may excite a morbid sexual appetite, so, conversely, the sexual appetite may be morbidly excited by pathological irritation of the cerebral paths and cerebral centres of the sensations connected with the exercise of the generative functions. To the former belong the satyriasis or nymphomania, occasionally observed in connection with disease of the middle lobe of the cerebellum; to the latter, the various morbid exhibitions of the sexual appetite in insanity, where the centres are functionally or organically diseased. From certain facts of experiment we have seen reason to conclude that the centres of sexual feeling are probably localizable in the regions connecting the occipital lobes with the lower and inner part of the temporo-sphenoidal lobe.

"As the reproductive organs in women form such a preponderant element in their bodily constitution, they must correspondingly be more largely represented in the cerebral hemisphere, a fact which is in accordance with the greater emotional excitability of woman, and the relatively larger development of the posterior lobe of the brain."

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Foster (*Physiology*, page 662) says: "The nervous centres connected with the sexual and generative organs are seated in the lumbar spinal cord. All or nearly all sexual phenomena may be witnessed in animals, the lumbar spinal cords of which have been isolated by section from the rest of the cerebro-spinal system." Galvanic stimulation of the cerebellum produces no change in the generative organs, and when erections of the penis are caused by emotions, the tract connecting the cerebral convolutions with the erection-centre in the spinal cord passes straight along the *crura cerebri* and *medulla*.

Foster mentions (page 693) the singular case of a dog whose spinal cord had been severed in the *dorsal* region. The "heat," or menstruation, occurred as usual, attended by all the ordinary phenomena, psychical as well as physical.

Impregnation was effected, and the animal became gravid; the pregnancy, like the heat, was marked by the usual signs; the mammary glands enlarged, and the usual mental accompaniments of the condition were present. The puppies were born, and post-mortem examination showed that there had been no regeneration of the divided spinal cord. In this case the connection between the ovary on the one hand and the mammary gland, brain, etc., on the other, must, if a nervous one, have been formed by the abdominal sympathetic.

When the lumbar cord is destroyed, Ergotin, Strychnine, and Picrotoxin fail to cause contraction of the uterus, because these drugs do not act on the sexual centre of the brain, but on the centre in the lumbar cord. But electrical stimulation of the sexual centre of the brain will cause contraction of the uterus, often when the lumbar cord has been destroyed.

If other proof was wanted to illustrate that the centre of sexuality is in the brain, that proof can be supplied in the unexpected results of removal of the ovaries and other reproductive organs.

Dr. Goodell (*Lessons in Gynæcology*, page 347), treating of the operation of "spaying," or normal ovariotomy, in answer to the objection that it "unsexes a woman," says emphatically that it *does not*, any more than castration unsexes a man. In both, the ability to *procreate* only is lost. In both they retain their sexual feelings, the power of intercourse, etc. "The seat of sexuality

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in woman has long been sought for, but in vain. The *clitoris* has been amputated, the *nymphæ* excised, and the *ovaries* removed, yet the sexual desire has remained unquenched. Its seat has not been found because sexuality is not a member, or an organ, but a *sense*, a sense dependent on the sexual apparatus, not for its being, but merely for its fruition. The physical and psychological influence of the ovaries upon woman has been greatly overrated. The truth is that the absence of the ovaries causes, in general, simply the same changes which attend the menopause (or change of life); but these changes are not always so marked, and they never so wholly modify the body and the mind as has been asserted."

A woman without ovaries may have all the peculiar changes of puberty, may menstruate, and have all the passions of other women. All she is destitute of is the inability to conceive.

Dr. Battey, whose testimony is of the greatest value, says that, after the ovaries are removed, the woman, instead of losing any of the characteristics of her sex, actually gains in flesh, strength, beauty, and attractiveness. Their singing is better, for the voice is stronger and sweeter.

Peaslee says the majority of his cases, after double ovariotomy, became "splendid specimens of womanhood," in every respect.

Atlee reports a case of double ovariotomy, where marriage took place after the operation, and "the sexual feelings were normal."

Verneuil found a patient, six months after a similar operation, with well-developed breasts, and decidedly fatter. "She, in fact, seemed far more of a woman than before."

Goodell says the history of his own patients confirms the above. "They are not conscious of any physical or psychological changes whatever, and they have also become better-looking."

This should not surprise us when we consider that disordered or diseased ovaries doubtless irritate directly the sexual centre in the brain, causing thereby abnormal influences to flow all through the body, changing its normal aspect and sensations.

Winslow (*Disease of the Brain*) makes the suggestive observation that one of the several signs of senile softening, at a time

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when all the sexual organs are supposed to be dead, is an "*intense pruriency of thought and action.*"

Nymphomania and erotomania may occur when all the sexual organs are absent or destroyed by disease; in fact, they are not disorders of the sexual organs at all, but of the brain, or rather of the centre of the sexual sense in the brain. The same may be said of the majority of cases of hysteria, that the real seat of the nervous disturbance may originate in the brain.

In addition to these proofs I beg leave to call attention to the "pain in the back of the head," the "occipital cephalalgia," which is so very common an attendant in nearly all uterine diseases. It is described as deepseated, dull, heavy, and at times very severe. It generally attends two opposite conditions, viz., (1) uterine and ovarian irritation, and (2) exhaustion.

I have found it very frequently in irritation from sexual excesses and unsatisfied desires. In the former case the irritation set up in the ovaries and other organs is reflected to the cerebral centre; in the latter the congestive irritation, not finding natural vent, is reflected back to the brain. The late Dr. J. S. Douglas once related before the Illinois State Homœopathic Society the cases of two engaged lovers, who, on the eve of marriage, indulged so excessively in mutual and passionate caresses, without sexual intercourse, that after separating both were seized the same night with terrible occipital pains, followed by delirium, convulsions, and death.

In my work on *Sterility*, I have recorded a case of intense occipital pain, the result of excessive intercourse. This pain lasted for weeks, and was only cured by temperance and material doses of Monobromide of camphor. I have also known cases where the occipital pain *appeared* to precede ovarian irritation, and was followed by ovarian and uterine congestion.

To sum up the whole matter, it may be stated that the latest and best authorities claim that the seat of sexual power is seated in the lumbar cord, and that all the essentials of sexual excitement and gratification may take place entirely independent of any portion of the nervous system above the lumbar region. Also that erection or congestion of either male or female genitals are due to the influence transmitted from this centre to the vaso-

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motors. This may be either direct to the vasomotor nerves, or transmitted through the medulla oblongata to its vasomotor centre, and from thence to the local vasomotors.

That there is an additional intellectual sexual centre can scarcely be denied, as we know that in man passion, and even the entire act, may be produced simply from intellectual or will source.

It does not seem to be settled whether this takes place through the will acting on the local vasomotors, producing congestion, and this congestion transmitting the peculiar stimulus necessary to the lumbar centre, or whether there is a seat of sexual sense in the middle lobe of the cerebellum, which may act independently of the lumbar centre.

However, the vasomotor connection is sufficient of itself to account for the reflex symptoms and conditions appearing at the base of the brain in connection with abnormal conditions sexually. These results are, of course, obtained by influences from *local* vasomotors to *the vasomotor centre*, which is in the medulla oblongata.

The object of this paper is to inquire whether many of our medicines do not act on the generative organs by primarily irritating the centre of sexual sense in the brain.

The recent discoveries in the domain of physiological science shed new light on the meaning of the symptomatology of many of our most important medicines. The experiments of great physiologists on man and animals, especially relating to the functions of the vascular and nervous systems, have shown the significance of the symptoms that arise in the course of disease, so that when certain symptoms are present we can trace the morbid phenomena back to its origin with almost absolute certainty. In the same manner we can discover the locality and character of the lesion or derangement caused by drugs, as evolved in our systematic provings, without making pathological or toxical experiments to the extent of destruction of life. We do not absolutely need to examine and note the changes in the integrity of organs, as shown by post-mortem. For example, if we observe certain symptoms in a prover, which invariably result from irritation of a particular area in the brain, we are just as certain that the drug caused irritation of that area as if we had examined

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that area after death and found evidence of irritation, congestion, or inflammation. As physiology and pathology advance, so will our knowledge of drugs advance in equal degree.

Classification of Medicines.—In the present state of our Materia Medica, and our knowledge of the positive affinities of drugs, we can only approximate to a classification of those medicines which act upon the sexual centres. But the following may be of some value as an attempt at such classification.

There are three classes of drugs which specifically affect the female generative organs, namely:

CLASS I.

Medicines Acting on the Cerebral Centre.—Aurum, Ambergris, Asafœtida, Bromine, the Bromides, Baryta, Belladonna, Cannabis indica, Coffea, Conium, Castorium, Camphor, Gelseminum, Helonias, Hyoscyamus, Lilium, Moschus, Picric acid, Platinum, Nux moschata, Stramonium, Sanguinaria, Sumbul, Staphisagria, Zincum, Valerian.

This class acts on the sexual organs through the vasomotor centre in the medulla, or that supposed seat of sexual sense which lies in or near the occipito-temporal convolutions. Of these, Asafœtida, Ambergris, Camphor, Castorium, Moschus, Sumbul, and Valerian probably act on the cerebral centre even in minute doses, through the medium of the sense of smell. Others may act through the sense of taste, the imponderable atoms being conveyed directly from the tongue to the sexual centre. Or, possibly, both may act on their respective centres, for which they have an affinity, and divert the irritation from the sexual to the centres of smell and taste.

It is a suggestive fact that Helonias, known to be a great remedy in diabetes, is also a specific for certain morbid conditions of the ovaries and uterus, attended by mental depression.

It is well known that irritation of certain portions of the cerebellum and medulla will cause diabetes. Helonias may cause diabetes by irritating the diabetic centre, and not by any specific action in the kidneys. The diabetic centre is near the centre of tactile sensations, and near to the supposed sexual centre.

Of the others, some of them act also on the spinal cord, and

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probably on the lumbar portion. Among these are Conium, Belladonna, and Picric acid.

CLASS II.

Medicines Acting on the Spinal Centre.—Agnus castus, Apis mel., Cantharis, Æsculus, Borax, Caulophyllum, Cimicifuga, Cocculus, China (Quinia), Gossypium, Ignatia, Jaborandi, Lachesis, Nux vom., Phosphorus, Picrotoxin, Phoradendron, Ruta, Sabina, Sepia, Secale, Strychnine, Ustilago.

All of Class II are special spinal irritants, although some of them may have also an irritant action on the brain.

It is therefore possible that the medicines in these two classes produce disorder of the sexual organs by irritating simultaneously the cerebral or lumbar sexual centres.

CLASS III.

Medicines Acting Directly on the Ovaries or Glandular Sexual Organs.—Aurum, Agnus, Apis, Caladium, Conium, Clematis, Baryta, Hamamelis, Iodine, Lachesis, Lilium, Phytolacca, Pulsatilla, Mercurius, Podophyllum, Sulphur, Thuja.

It is more than probable that all medicines acting on the testicles act also on the ovaries, for they are homologous organs.

This third class includes those which have a specific affinity for the *ovaries*, uterus, etc., acting upon their tissues directly, or by influencing their blood-supply, or their innervation, probably by an action on the local vasomotor nerves.

It may be asked how we may recognize the medicines which belong to these classes. I answer, *by a study of their pathogenesis*, or rather a study of the daily records of the provers. Unfortunately the day-books of the provers of many of our valued medicines are lost, but enough remain to give us a clue to the action of some of them. In the case of Secale and Sabina, the lumbar centre is doubtless first attacked, and the cerebral centre, if affected at all, is only a reflex symptom. With Lilium the cerebral centre is first irritated, and this irritation is rapidly transmitted through the sympathetic system directly to the sexual organs, particularly the ovaries and uterus, possibly without passing through the lumbar centre in its course.

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But with Picric acid, the lumbar and cerebral centres seem to be irritated simultaneously. The turgescence of the bloodvessels at the base of the brain, the spinal cord, and the sexual organs occur so nearly together that it is difficult to distinguish which location was first affected, if indeed there was any difference in time. Our provings of Picric acid on women are very meagre, but we can judge by its symptoms in men that it must have a profound irritating action on the uterus and ovaries. Guided by this analogy I have found it one of the most successful of all our remedies in purely congestive conditions of all the female generative organs.

I consider the primary action of Picric acid and its salts on the spinal cord and brain as purely irritative. The congestion is a result of this irritation. It affects the animal sphere of sexual life. The sexual centre in the brain is partly animal and partly intellectual; Picric acid acts on the former, while Cannabis indica acts on the latter. This sexual centre lies very close to the centres where the senses of smell and sight have their origin. In the lower animals and lowest type of man this sexual centre is excited by certain animal odors and by the sight of voluptuous objects. In the higher types of man and woman the intellectual portion of this centre is mainly excited by the higher emotions and by reading a certain kind of emotional literature *Cannabis indica*, by its primary action, directly excites this intellectual portion of the sexual area in the brain. The congestive phenomena follow as a direct sequence or result.

If the lumbar portion of the cord is paralyzed the animal can feel the sexual impulse or emotion, but no erection or procreation can follow. If the cerebral centre be paralyzed erection and procreation could follow, but it would be almost a mechanical act, destitute of emotional or intellectual impulses.

In prescribing the Picrates for ovarian or uterine disorders, these facts must be borne in mind. If after getting a history of the case we arrive at the conclusion that the spinal and cerebral irritation preceded the uterine or ovarian irritation, then Picric acid is the remedy, and so long as the congestion and erethism is acute it should be prescribed in a high attenuation; but if this

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acute stage has passed, and a paretic or paralytic stage is present, then more material but still quite minute doses are indicated.

Cannabis indica, on the contrary, is indicated when the history of the case discloses that the congestion and irritation have been caused by intellectual or emotional influences, and there is present a peculiar exaltation of the emotional sphere and a hysterical condition is impending or actually present.

Picric acid has many affinities with Aurum, while Cannabis is closely allied to many of the effects of Platinum and Lilium and probably Staphisagria.

But while the pathological states may be similar, the symptoms may be different, and here the value of symptoms is shown as guides in the selection of the remedy.

In conclusion I desire to say that this paper is not intended to be complete, and certainly not exhaustive. The sciences of pathogenesy, physiology, and pathology are not sufficiently advanced to warrant any strictly logical deductions relating to the manner in which medicines act upon the generative organs of women. The writer will feel amply satisfied if he is successful in calling attention to these facts: (1) That diseases of the female organs of generation do not always originate in the tissues which make up the organs themselves, but do frequently, oftener than we suppose, perhaps, originate in the spinal and cerebral sexual centres; and (2) that medicines when taken by healthy persons do not always cause disease of the uterus and ovaries by acting directly upon them, but in many instances by acting either on the spinal centre in the lumbar cord, or the cerebral or intellectual centre of sexual organs in the brain; and (3) that in order to successfully treat uterine and ovarian disease, both functional and organic, we should ascertain in which nerve-centre the primary irritation originated, or whether in the tissues of the organs themselves, and select the medicines in accordance with their primary affinities so far as it is possible in the present state of our science of pathogenesy.

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ON THE USE OF INTRAUTERINE STEM PESSARIES.

By Mrs. E. G. Cook, M.D., Chicago, Ill.

I desire to give to the profession a little of my experience in the use of intrauterine stem pessaries. I use the plain rubber for simple flexions, and the copper, zinc, and rubber combined where the uterus is engorged and granulated. I have changed the ball on Simpson's old zinc and copper stem for a rubber cup, as the old one would not remain in place without packing and keeping the patient in a prone position. The size and shape of this cup is, like the stem, varied to suit each individual case. As long as women make shoulders of their hips and carry the clothing upon them, as long as they wear the murderous corset and strap the stomach, liver, and bowels downward, and push the lungs and heart upward, so long will physicians have to treat uterine flexions. Supported as it is by the elastic vagina what can the organ do but double up, twist upon itself, and assume the many forms of dislocation which the gynæcologist finds in daily practice. If the flexion is recent it is usually easy to straighten and insert the right-sized stem and cup for retention. In retroflexion the patient is instructed to lie upon her face with her knees drawn up under her, to creep frequently, and avoid resting or sleeping upon her back. These cases are frequent. The habit of retaining urine a long time in the bladder is a provoking cause of this malady. A lady consulted me recently whose troubles had begun to assume a decided chronic form. She had been subject for a year to sudden attacks of uterine colic from apparently slight causes. Putting on thin shoes for an evening, going without overshoes, even in warm spring days,

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would put her in bed for a month. Food which created gases in the stomach would induce an attack, requiring all the skill and power of her physician to subdue. When I first saw her she had been in bed six weeks, and she assured me this was the fourth or fifth attack in the past year. I dilated the sensitive and flexed womb with a bent sponge tent, packing with glycerin and absorbent cotton. I removed the tent the next day and introduced a rubber stem. This not only relieved the pain and sensitiveness, but helped to put in the natural position a prolapsed ovary, which threatened to make the case a bad one. She had no more trouble and made a rapid convalescence. In cases of anteflexion the patient is instructed to lie upon her back and to knead the bowels near the pubes frequently, and in all cases to remove every ounce of clothing from the hips and wear as loose clothing as men wear. One of the first patients who consulted me for anteversion, after my removal to Chicago, was Mrs. P., of Wisconsin. She had been nine months without menstruating, and the womb was enlarged and indurated. She had terrible and frequent headaches, a flushed face, and although but 30 years of age had grown very stout and clumsy. I dilated the sharp flexion with bent sponge tents, first dipped in cocoa butter to render them easy of introduction. The treatment was slow and painful at first, and so great was the nervousness that I sometimes almost despaired of ever inserting a stem. The application of Sanguinaria and Glycerin, however, helped me in overcoming the sensitiveness, and Caulophyllin 3^x was given as covering most of her symptoms.

On the fifth day I inserted a slightly bent copper and zinc stem, and within a week she menstruated freely, and the flow continued for six weeks, some of the time profuse. The stem was removed and cleansed once a week, as in a few days it is covered with oxide of zinc, which becomes an irritant. In a thin, weak patient I should have removed the stem after five or six days of the flow, but her head had ceased to ache, the flushed face became natural, her neuralgia disappeared, and she could walk better than for years. I felt she could with benefit bear a little depletion. At the end of this time I removed the battery and introduced a rubber stem, which she has worn since, now nearly

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two years. When she comes to town, spring and fall, to do her shopping, and after it is done, I examine her and change the stem as often as the decreasing size of the womb makes it necessary. The organ is now soft, straight, and healthy and about half its original size, the monthlies are regular, and she has lost thirty pounds of flesh. I shall soon remove the stem and expect pregnancy, which is greatly desired. If we have to deal with a double flexion, or a twist instead of a bend, the physician should study carefully the position the patient must assume while at rest.

A Miss V., of Indiana, aged 21, whose relief seemed miraculous to her friends, was brought to me at the Palmer House in 1876. She began to menstruate at fourteen years of age with great pain, which increased in severity until I saw her. For three years previous a physician was always in attendance at her monthlies, night and day. The family made as much preparation for these times as is usually made for expected children, and father, mother, and only sister gave their entire time in caring for her. Spasms of pain, alternating with vomiting, succeeded each other, sometimes for thirty-six hours. During these spasms a few drops of menstrual fluid would be forced upon the one napkin, which was all that was required for the entire time. Her attempts to relieve herself by clutching with her hands the lower part of the abdomen, sometimes until she drew blood, were painful in the extreme to those who witnessed them. The flesh would often remain blue for days. At the end of this time she seemed stupid, and only rallied and appeared herself about a week before the next period. (It was greatly feared that her mind would suffer in case she should recover.) After three days and nights of this agony she sank into a comatose sleep and awoke with one-half of the body paralyzed. The physician who was in attendance (they had employed many) took her father aside and told him that, without doubt, at the next return of the monthly, his daughter must die. The nervous system had given out, and there was no hope.

While she was still too weak to walk she was brought to me at the Palmer House, one week before the dreaded time. I found a double flexion, or a twist and a flexion with prolapsus.

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I began treatment by dilating with sponge tents, using two daily, as the time was so short. After the fourth day she menstruated freely, without a pain or a feeling of nausea. This was the first painless period of her life. The cause of all this trouble was attributed to jumping the rope, sometimes jumping three or four hundred times without rest. (Is it not the duty of physicians to instruct mothers in regard to the physical education of girls, in order to avoid such calamities?) After a week I again dilated with sponges as before, using one daily for three days. I then introduced a rubber stem a little bent, which she wore two months. This was then changed for a straight one, which she wore a year, with an occasional treatment, when she was discharged cured. In the meantime the flow had increased to its normal quantity, and she rarely ever experienced the slightest pain or nausea.

When sterility is caused by flexions, as it frequently is, the patient usually grows stout, the menses decrease in quantity, and the uterus enlarges. Query: Is the corpulency in consequence of too scanty flow on account of the flexion, or does the corpulency cause the flexion? The use of the galvanic stem, carefully watched and cleansed once a week, is usually all the treatment required. The case which I will relate was different, however.

A Mrs. G., of Calumet Avenue, consulted me in January, 1876. She had been married eleven years without children, and greatly desiring them, as most women do who see the years go by without them.

I found the uterus not quite two inches long, with thin walls, a tortuous cavity, and the body shrivelled and rigid. The menses had always been scanty, painful, and irregular. She had for years been under different gynæcologists in Chicago without benefit. Her anxiety was so great that she persisted in coming in all kinds of weather. I often chided her for exposing her health in so doing. I dilated the twisted canal for three days in succession, when the sensitiveness compelled me to rest. After three weeks of care, using hot enemas and taking internally Arnica and Caulophyllin, I again dilated and introduced a short rubber stem. This had to be packed to keep it from being thrown out by contractions. After wearing it for a month,

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except the days when from constipation or some thoughtless movement it would be thrown out, I again dilated and introduced a larger stem. This treatment was continued at intervals for a year, when I told her that I felt all had been done that could be. Her womb had grown straight and to a normal size, was soft and natural, and she could wear a stem three-quarters of an inch longer than the first. There was more flow and regularity. I directed her to wear the stem six months longer, to fortify against a relapse and allow time to grow strong. It was then removed, and I heard no more from her until she came in great joy to consult me in regard to her confinement. She now has a boy a year old, the finest in the world—*so she says.* She desires me to send discouraged patients to hear her story and see her boy.

A case of polyp and fibroid tumor was cured with medication and the galvanic stem. When Mrs. K., of Michigan Avenue, consulted me, her uterus measured three and a half inches. There was a fibroid tumor upon its posterior wall as large as an orange. The organ was retroflexed; the tumor lay upon the rectum, causing great trouble in defecation. It also created a nervous condition, at times amounting to mania. She could not endure the presence of her dearest friend. She had a lump in her throat, and a curling (as she termed it) under her tongue. I straightened the flexion and dilated the uterine cavity; it was filled with soft polyps, which I removed by torsion. To prevent hæmorrhage I washed it out with a weak solution of Argentum nit., and left it for two days, with a dressing of Sanguinaria and Glycerin. At the end of this time it had remained straight, and had contracted sufficiently to hold a galvanic stem one-quarter of an inch in diameter and three inches long, with a rubber cup one and a quarter inch in diameter. This was removed and cleansed once a week for a month, when it was changed for a smaller and shorter one. These changes were repeated, as the conditions required, for a year, sometimes using the galvanic and sometimes the rubber stem. The monthlies were regular, and in the intervals there was sometimes a mucous and sometimes a bloody, muco-purulent discharge of a bad odor; the large quantity of these discharges was a noticeable feature of the case. At

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the end of the year the uterus was reduced to nearly its normal size, and the tumor to that of a small hickory nut with the hardness gone. There was no more trouble at stool, and the nervous symptoms had disappeared entirely. To use her own language, she was as well as Eve was, and certainly looked the picture of health. This, as well as the following case, which the galvanic stem so signally aided, are typical of scores of cases which, within the last ten years, have grown well in my hands, and makes me desire to add my testimony in its favor, when *understandingly* and *carefully* used.

A Miss D., of Randolph Street, aged 30, had suffered from bronchial trouble two and one-half years, with entire loss of voice. During the entire time she had not menstruated. The womb was atrophied, bent upon itself, and occupied the left ovarian region. It was with great difficulty reached and dilated, and a small bent galvanic stem introduced. She immediately menstruated scantily; the discharge was thick and almost black. After a few months it became natural, recurring regularly and without pain. I then changed it for a rubber stem, which she has worn nearly two years. She has gained twenty pounds of flesh, and is able to carry on a dressmaking establishment. Although she still whispers, I believe if she could change climate she would soon regain her voice. When she came to me she was not expected to recover from bronchial consumption. The remedies which I have relied upon in most cases are Aurum, Caulophyllin, Hydrastis, Sulphur, and Calcarea. For the nervous symptoms accompanying these disorders, Hyoscyamus, Ignatia, Belladonna, and Ipecac.

The greatest care is required on the part of the surgeon in measuring the uterine cavity, and in selecting the right stem, in order to avoid irritation or inflammation. The galvanic stem must be cleansed weekly, to avoid irritation or inflammation. When the flexion is sharp and the organ sensitive a small tent, made from slippery-elm bark, partially soaked, will often aid in the introduction of the sponge tent or stem. The bark of the tree is only useful, as that of the root is too brittle. If the womb is engorged, ulcerated, or sensitive, a poultice made of pulverized Sanguinaria and Glycerin, and applied on cotton to the

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mouth, for several days, will relieve these conditions and render the introduction of tents less painful. No *force* should ever be used by the surgeon, but the gentlest manipulations. We should always cease efforts when the patient complains. There is, however, great difference in the sensitiveness of different individuals; some will complain before the instrument touches them, while others, in their extreme anxiety to get well, will endure great suffering without a murmur; hence the absolute need of watchfulness on the part of the operator. Accompanying the use of the stem pessary frequent enemas of hot water are recommended. All kinds of pessaries which distend the vagina should be used for fuel, instead of rendering many hopeful cases incurable. I have cut away from two patients a hard rubber which pressed so hard upon an inflamed mucous membrane as to become imbedded in it, and remained, in one instance, two years to torture and make miserable the life of the patient, if indeed life was not imperilled by its use. All supporters and hard instruments which compress the muscles should be ignored.

The army of women and young girls is growing fearfully large who suffer during menstruation from flexions, membranous menstruation, and a host of other causes. We may as well acknowledge the fact that, with the multitude of specialists in gynæcology, diseases of women do *not* grow less frequent. To obtain a thorough knowledge of these requires much experience and manipulation. As a rule women are sensitive in regard to these manipulations, and prefer women as physicians. Of course there are exceptions, but we are told, times without number, that it is such a relief from embarrassment, and such a comfort, to talk to a woman who has knowledge and experience, and who, from the nature of things, *must* have sympathies which men cannot have. I believe that God intended women to supplement men in treating the diseases peculiar to women. I feel extremely anxious that every woman who takes upon herself the holy office of physician should be all that good, grand womanhood implies. That they shall feel the momentous importance of physical education, especially among their own sex, and who see in it the redemption of the race. We may then hope to see a generation of mothers able to give birth to healthy and well-developed

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children, without instrumental aid; mothers not forced into maternity, and who ignore all modern inventions to avoid the responsibilities of married life. Such mothers wait anxiously to greet each new life, assured that it will not grow up in sin. Children born of such mothers will be freed from the unrest of those born under protest, and will possess the *possibilities* of a moral nature. This glad day is dawning. Its glorious beams gild the hill-tops, and whiten the gray light in the valleys. Let us rejoice that the days of ridicule and persecution are over, and work with a will to aid our brothers, not only in curing the sick, but in teaching the laws of prevention, remembering "to do unto others as we would that they should do to us."

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APPENDIX.

DISCUSSION.

SECTIONAL MEETING OF THE BUREAU OF GYNÆCOLOGY.

R. LUDLAM, M.D., of Chicago, Ill., Chairman: *Ladies and Gentlemen:* I am very much obliged for the compliment you have made me by putting me in the chair, temporarily, of this bureau and these proceedings. The object, as I understand it, of this sectional meeting, is to save the time of the Institute and secure a more thorough discussion of at least one of our reports.

The bureau has concluded to recommend the reading of the paper of Dr. Biggar, of Cleveland. The paper is on the subject of laceration of the cervix uteri. This is a subject attracting a great deal of attention now, and which I am sure the members present will listen to with a great deal of interest. Our first business therefore to save the time of the members present will be to at once hear from Dr. Biggar.

H. F. BIGGAR, M.D.: In presenting this paper a word or two probably had better be said. It is true that this subject is attracting a great deal of attention at the present time. The matter has of late years attracted a great deal of attention. It is not my intention in this paper to present altogether my own views, but to present the views of one or two of the leading gynæcological surgeons of the day, in the hope that it may elicit a discussion from which we may derive some benefit, and which may also give us some knowledge in regard to the experience which each may have had in regard to the necessity of an operation of this character, and if it is not sometimes resorted to when it is not necessary, and if it is not, at other times, too much vaunted in regard to its benefits; for this reason, and on account of that fact, I have presented the paper at the present time and brought the subject forward.

The paper was then read by Dr. Biggar.

The CHAIRMAN: Gentlemen, one of the objects, as I have

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said, in calling this sectional meeting, is to have a thorough discussion on at least one of the papers presented by the bureau. This is a very interesting paper; you have all heard it, and it is now before you. I wish to remind you that we shall have to confine ourselves to as limited time as possible in speaking. I wish also to say that we have our friend Dr. Morgan with us, who is taking the discussion down so that it may be preserved, and appear in the volume of *Transactions*. Whatever is said here is said for the benefit of the Institute and the profession at large. The members of the bureau will be glad to hear from other physicians. The first one I shall call is Dr. Walker, of St. Louis, to give us his views about lacerations of the cervix uteri.

G. S. Walker, M.D., of St. Louis, Mo.: Within the last year I have met with a number of cases of this character. I have assisted in operating on several, although I have never performed the operation myself. I think contrary to what the doctor recommends. I think the best position is to place the party in the knee-elbow position, placing her on a table or on something solid with support for the abdomen, and thus you have every facility for getting the light and assistance, and for reaching the uterus in order to operate upon it. I will say that although I never actually did the cutting, I have done all the other parts of the operation, so that I know something about it in that way. The wounds that we operated upon were both double. They were lateral lacerations and double on both sides, but they were perfectly successful so far as the healing up was concerned. The uterus in each case was enlarged and was treated beforehand so as to reduce its size just as Dr. Biggar recommends. When the inflammation, hardness, and tenderness were gone, then the operation was performed. The ligature was made with wire, but also I think that some silk ligatures were used. The operation has been done in my presence several times. It heals much more rapidly with the silk, because the parts are not in a place readily accessible to any great extent. It is not like sewing up the perinæum, which will be likely to be torn apart. The uterus is not the only thing—there is the trouble of getting at it for the manipulations of the operation, the difficulty to the surgeon of using the instruments in the introduction of the suture, and taking them out at the right time, and the leaving them in or taking them out at too short a time; all these matters are to be considered in the operation on the cervix uteri. The centre of the cervix should not be denuded; you must always bear in mind to leave a place for the cervical canal.

Dr. Allen, Ann Arbor, Mich.: I would like to ask if he

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places the patient in position before administering the Chloroform.

DR. WALKER, St. Louis: Yes, sir. There was one who did not take Chloroform very well. The main thing in this operation is to have plenty of assistance. It is better to have more than you want than not enough in this operation. To do the operation correctly you will need at least five assistants besides the operator himself. Not less than that, and six would be better. One physician should give the Chloroform, paying his whole attention to that and nothing else. There should be two assistants, one on either side, to separate the parts with the hand; this is much better than to use any instrument there.

DR. ALLEN, Ann Arbor, Mich.: Do you elevate the chest?

DR. WALKER: Yes, sir. Generally by means of a box about two feet high placed upon a table. I put a pillow upon it and then have a pillow for the knees of the woman, at the same time she leans over the box, and there is no compression of the chest. The force of the box is on the abdominal part of the chest, but not altogether. There is plenty of room to breathe. I see no trouble about it.

DR. EATON, Cincinnati: I would inquire the object of putting the patient in that position.

DR. WALKER: The object of putting the patient in that position is to obtain more light. Everything is ready for the operation. The parts are separated by assistants, one on either side; neither of them stand in the light.

DR. VON TAGEN, Chicago: I have not much to say in respect to cases of this kind. I have had a few cases, in the course of my experience, of lacerated cervix uteri. Most of them, however, have been recent cases. I have always taken the precaution to examine the parts after the patient has passed through delivery. I have also had a few cases of delayed union. I simply want to say a few words in regard to the ligature. I think it is important for us to pay attention to the quality of ligature that we use. There is great objection to the use of the silk ligature, and I abandoned it entirely. I think we are very apt to have, and I know we are very apt to have, a profuse suppuration with the silk ligature, for the simple reason that the silk absorbs and becomes foul; and where you would expect union by first intention you will be sure to have suppuration, especially in these cases. The silver suture is, therefore, in my opinion the best, as union by the first intention is much more apt to follow the operation than from the use of the silk ligature. I have obtained union in from four to five days. This has been the case as a rule. It sometimes takes place on the sixth day.

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But there is no special rule that can be laid down as to a certain day. I would also state in regard to the use of the anæsthetic and the attitude, I have myself used Chloroform in these cases. The position of the patient on the left side in my opinion is decidedly the safest and the best. I think that you are taking considerable risk in using Chloroform in the attitude which has been referred to by the gentleman from St. Louis. It strikes me that the respiratory organs are too much interfered with in that attitude. Notwithstanding there is no pressure by the plan he suggests, still the patient being in a reclining position with the head so downward, I do not think it is a safe position in which to administer an anæsthetic.

Dr. Walker, St. Louis: May I explain one word. My attention was not called sufficiently at the time to the administration of the Chloroform, so I did not state exactly what was the truth in the case. In one case I know we could never give any Chloroform at all. It is an operation attendant with very little pain, so that many operations are performed without the use of Chloroform. I had forgotten this fact at the time I was speaking before. The woman stood the operation without saying a word. I remember distinctly that no Chloroform was given. It is not a painful operation in the ordinary acceptation of the term.

Dr. Ludlam: I am glad that we have the explanation. I now call on Dr. Philip Porter, of Detroit.

Dr. Philip Porter, Detroit, Mich: I did not intend to say anything on the subject. The only point in regard to this operation which I think has not been touched upon so far, and one that I am particular in, is the sutures. I think that those who try the horsehair suture will prefer it, especially when the time comes to remove the suture, then they will be much better satisfied with the horsehair suture than with either the silk or the wire suture. It is very elastic. It is a suture which you can leave, if you wish, eight to twelve days without having any suppuration. It is so elastic that when you snip the suture it will fly apart, and with a pair of forceps you can remove it. I prefer it to any other kind of suture. I do not wish to put this in as an offset against the other sutures, because I have not had the experience that some of the older members of the Institute have had.

Dr. O. S. Runnells, Indianapolis: I would like to ask you how you secure the sutures?

Dr. Philip Porter, Detroit: My plan is to take a double turn. It is as easy to introduce as the wire suture or the silk suture. In using the horsehair suture you will experience much

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satisfaction. I got in the habit of using it in the operation for hare-lip. I think there is nothing in the world equal to it in that operation. I have also used it in other operations, and prefer it to any other.

MRS. DR. COOK, of Chicago: I would say that while it is nice to know just how to do these things well, we ought to study beforehand how to prevent the accident by attending to the condition of the patient beforehand. I have delivered 2000 women and never had a case of this kind.

DR. R. LUDLAM, of Chicago: So far as you know or could discover; won't you qualify it?

MRS. DR. COOK: I believe I do know.

DR. BIGGAR, of Cleveland: Mrs. Dr. Cook has suggested a very important feature, the preventive measure, and I think before she sits down we should like to hear what she does to prevent these things. In doing so I beg that Mrs. Dr. Cook will come forward and take a seat in front.

MRS. DR. COOK: Your inquiry I believe is made as to what measures I would use to prevent this accident. I would say that as far as the general health of the patient is concerned that attention should be given to hygienic measures, and attention to the os before confinement. I find that it facilitates labor and makes it easy to have a healthy os. A great many ladies have an ulcerated os and ulcerated vagina before confinement. My plan is to use hot water injections, and general hygienic measures such as the case may require. Those are the means that I use; I do not think of anything else.

DR. R. LUDLAM: The attention is not during labor especially.

MRS. DR. COOK: No, I think not. I have sometimes used hot injections during labor and hot sitz baths, the heat to be applied in different ways. I have also sometimes used a little Belladonna, but that would not be homœopathy. In the early stages of labor I use a preparation, but not a strong preparation. I don't know that you allow such hints to be thrown out.

DR. R. LUDLAM: We allow any one to say what they please here. Has your question been answered, doctor?

DR. BIGGAR: Mrs. Dr. Cook has answered my question. What application would you make to relieve the os previous to labor? Would you use the Belladonna cerate? That is the question that I asked, as to what is used in the early stages of labor?

MRS. DR. COOK: Yes; it then produces an excellent condition of the uterus. If the uterus is not soft I pay special atten-

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tion to it, and use those measures of which I have spoken before.

DR. BIGGAR: Would you examine the os at any time?

MRS. DR. COOK: Always during the impregnation until the last day of labor. The question was asked whether I would examine the womb and the os until the day of labor, and I said yes, until the very hour. But the manipulations and the remedies are to be applied of course with great caution. I find sometimes that ulcerations are more quickly cured during pregnancy than at other times; it seems to be a very good time to put the woman in the best condition.

DR. WALKER, of St. Louis: I would like to ask Mrs. Dr. Cook a question. I would like to ask if she is in the habit of examining the os after the labor is over, say within six weeks or two months.

MRS. DR. COOK: I examine it within ten days or within a day sometimes. I make an inspection to see if there is anything requiring attention. I use the syringes right along; I even had the patient syringed within two months.

DR. WALKER: After two months?

MRS. DR. COOK: Yes, sir.

DR. WALKER: Without any trouble or complaining?

MRS. DR. COOK: I make it the habit of watching the case until it is thoroughly cured.

DR. WALKER: You did not get at my question.

MRS. DR. COOK: What is your question?

DR. WALKER: You attend a woman until the end of the month and she is well as far as you can see; would you go and examine that woman a month after that if there is nothing out of the way?

MRS. DR. COOK: I should think that it was my duty to do so.

DR. WALKER: Suppose that she had not complained.

MRS. DR. COOK: That would not make any difference. If the lady was under my care and I attended to the family, I should not leave the family; I should consider it my duty to look after her until she was strong. This I have always done, at least during recent years.

DR. WALKER: I cannot say that I never had a laceration of the cervix uteri, but so far as I know I never have had one, and I have attended 2700 women.

MRS. DR. COOK: You beat me, doctor.

DR. WALKER: I never saw one of my own, yet I believe that they are there.

DR. LUDLAM: That is the point exactly.

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MRS. DR. COOK: I don't know why you should believe so.

DR. WALKER: What treatment do you recommend to prevent the frequency of this accident? I would say that about every thirtieth case that I examine of the women who come to me have it. I find them in my own cases,—some cases that I have attended for five or six times and some less; that every thirtieth case is troubled in this way, and I don't know whether the woman had the laceration when I attended her or not.

DR. ALLEN, Ann Arbor: Dr. Walker is just the man to answer the question how he prevents them.

DR. WALKER: I do not prevent them, and that is the only answer that I can give.

DR. BIGGAR: I think that Mrs. Dr. Cook has answered the question pretty thoroughly, and I am now going to ask Dr. Walker how he prevented this accident in the 2700 cases that he attended. What success have you had, and what do you do to prevent it?

DR. WALKER: I do not pretend to do it, that is to say, I do not know but what they may have had a laceration every thirtieth one, but I had no chance to examine them within one or two or three months after the labor was over, because they did not complain of anything, and my attention has not been called to it. That is the reason probably that I have not met with this accident before, or not until within the last two years probably. I say this much, that within the last two years I believe that it is the cause of a great many of the complaints of some women that we did not comprehend before. Of these 2700 cases every thirtieth one might have something the matter with her. They might have had a laceration for all I know. I did not know it, and I did nothing to prevent it. I only say this, that you may examine the woman for a whole month before, or for six weeks probably, and unless the laceration was very great you would not detect it.

DR. LUDLAM: I would like to suggest that until within two years nobody has known how to examine these cases for laceration of the cervix, nobody at all. We didn't know the means of finding them.

DR. ALLEN: May I ask Dr. Biggar the statistics. He says there will be found thirty per cent. of all impregnations resulting in lacerated cervix uteri. That is the first statement. He next made a statement in which he said that laceration was quite common, as common as an elongated cervix uteri; that certainly would not be the case, because elongated cervix is found in the unimpregnated uterus. We frequently find that condition of things. I may say while I am here that my belief is, that a very

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large amount of this difficulty is due to the peculiar haphazard way in which we do the business. We are general practitioners, instead of becoming obstetricians and attending to that alone. In other words, we have a large practice hurrying us, and we have several very sick patients. We are called upon to attend a primipara; we are in a hurry, our patients are all hurrying us up, and instead of waiting, as we ought to do probably, and applying our homœopathic remedy, as we might do, we resort at once to the forceps, and the result is a laceration, or perhaps we resort to massive doses of Ergot, and the result is a laceration. Now if we would practice obstetrics as we practice surgery, and let everything else alone except that specialty, giving our time and attention to the patients and working into this kind of business as a specialty, we would have very much less of this difficulty. I think also we should apply our homœopathic remedies previous to and during the labor, and by that means prepare our patients for the ordeal through which they are to pass. If we do that we will by this means escape a great deal of the laceration. We cannot always do it, because patients are not always willing. We do not insist on it enough perhaps. I think the difficulty in the way is that we are as a rule general practitioners, and we make no specialty of obstetrics. This should not be the case. Some of us should make a specialty of obstetrics and nothing else. We would then have very much less of this difficulty to contend with.

Dr. Lungren, Toledo, Ohio: Mr. President, I came into the meeting very late and I have missed hearing the greater part of the paper. I scarcely know what it contained in the beginning. I have listened though with great interest to the remarks of the different gentlemen and the lady, and I think I have obtained a good deal of information on the subject. There is one question that has arisen in my mind. I have had but little experience in the operation myself, having operated upon but two cases. My question is, Whether the operation is always necessary, or how often it is necessary? I have had patients come to me that have had quite severe lacerations of the cervix, but they did not seem to experience any suffering from it at all. Their general health was pretty good, aside from some other troubles which I have found frequently to be relieved by the homœopathic medicine indicated. There is a fashion, I am sorry to say, in gynæcological surgery to follow the lead of some person who puts out a treatise upon gynæcology. Immediately upon the appearance of a work of this kind every one almost throughout the country adopts the views of the writer, whether they are good or bad. Ten or fifteen years ago it was a good

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deal like the Irishman at Donnybrook Fair, whose motto was, if he saw a head to hit it; so with these gynæcological surgeons, their motto was, if you see a cervix incise it. Now the thing is all changed; when we see a cervix we sew it up. They could not be right all the time. It was their fashion to do one thing or the other. It is either right to do one thing or the other.

DR. DAKE: Or let it alone.

DR. LUNGREN: I am very happy to say that I think there is rather too much gynæcological surgery. I think some of the women of the land would be better off if we did not have quite so much.

DR. REUBEN LUDLAM, M.D., Chicago, Ill.: That is right.

SAMUEL S. LUNGREN, M.D., Toledo, Ohio: I have met two cases that were benefited by the operation. So far as the operation was concerned, it was a question whether they were benefited to any great extent. From my observation, I think that some are benefited and some are not. We have had several distinguished men who have made remarks upon the different varieties of sutures which are to be used in the operation. The gentleman from Detroit, I believe it was, who spoke of the horsehair suture. I indorse that fully; I have used the horsehair sutures for several years. They are clean, elastic, and when you cut them they spring open at once. There is very little separation of the parts. For my part, I think that they are preferable, in many respects, to silver or wire sutures. But they do not hold as tightly, and you cannot make as much compression upon the part with them. They are not apt to slip, although sometimes they may do so. As regards operations on the external surface of the body, I know that they are bad, but I have used them in the uterus with very good results indeed. I think that the operation is called for in some instances, and has been, as I say, a benefit, but I think there is a great deal too much done to the uterus very many times. It will get well under proper homœopathic treatment, judiciously applied.

R. LUDLAM, M.D.: I think, ladies and gentlemen, it is a very wholesome thing to have a gynæcological surgeon to speak to us. Dr. Lungren's reputation as a gynæcological surgeon is established, and his statements are very instructive indeed. We have made some progress in this direction—in the direction of gynæcological surgery. It means something. It is something that must be learned. Whatever opinion we receive from Dr. Lungren we may be sure it is not an opinion given by a man who never did anything, and it is certainly not the opinion of a man who is likely to do too much. The next man on the pro-

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gramme is Professor Parsons, of St. Louis. We would like to hear from him in reference to this paper.

Dr. Parsons, St. Louis, Mo.: I came here to listen and not to say anything. This is a matter, sir, that I feel a good deal of interest in, although I have not yet had as much to do with it as many others; but I am like Dr. Lungren, I think the operation is too frequently performed, and I can heartily indorse what he has suggested. It possibly may not be his own individual opinion that thirty out of one hundred cases have laceration. I read in a medical journal not long ago that a New York gynæcologist made a statement wherein this was corroborated. The statement was made that from thirty-three to forty per cent. of the women that came to his clinic, or to his private room for consultation, had laceration of the cervix. Now you obstetricians certainly ought to feel that you really do not understand your business here; you are at fault somewhere. If you do not know that these cases exist until your attention is called to it by the gynæcologist, I think it is about time that some of you were making further investigations; and, like the lady who suggested it, it would be well for you to examine the cases a little sooner and a little oftener than you do. Now, as regards the operation itself, we have lacerations where there is no earthly need for the adoption of any surgical operation. In the first place, as Dr. Lungren says, we may have severe lacerations that can be relieved had the patient complained of symptoms indicating such a condition. Then the question arises in these cases where the operation has been performed, Will the results of the operation be satisfactory? At the moment they may be satisfactory, but will they last? That is something that no one can tell. It takes time to prove whether the operation is one that is justifiable or not. All the symptoms indicating laceration, and the symptoms attending laceration, you might find from their pathological states. There is, I say, no doubt in my mind but you may go on with this subject to a great length. I had an idea that I wished to speak about something, but I have forgotten now what it was. However, supposing the operation is performed, supposing that you sew up the cervix, is there any guarantee that it will not occur at the next pregnancy? No one can tell that. You may have a laceration of a perinæum and sew it up, and your patient will pass through one or two succeeding pregnancies with no difficulty, and in the next one there will be a laceration again. And so it will occur with the cervix. This is a very pertinent question, and one which it is well to consider. There is another question that arises in my mind, and that is, whether or no all of these cases can be remedied by local and constitutional treatment? You must examine your cases. If

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you examine the cases afterward, you will find that there is a laceration there, and surrounding it a brown granulation. I have seen such cases. The recommendation is to amputate the cervix. That has been done. Again, we may have a large and an accumulating granulation there, after the epithelium has been denuded. Those cases may be operated upon with success, either by amputation or without; or by scraping the granulations off and applying a local treatment. Many of them will get well, while others will not get well until the laceration is removed, either by amputation or by incision and union of the flaps. I contend that in a majority of cases that have been operated upon in this country there was no necessity existing for the operation. What is the reason that we cannot unite a lacerated cervix by constitutional and local applications just as well as anywhere else? Is there any anatomical or pathological reason why we cannot do it? If there is I would like to have some one state it.

J. H. McClelland, M.D., Pittsburg, Pa.: Mr. Chairman, I have not directed my attention particularly to this practice. However, I have had considerable to do with these lacerations. As regards the frequency of the laceration, I think the estimate has not been overstated. There is no doubt but that one-third of the women who have borne children have lacerations of the cervix. This is as far as I have been able to discover, and I have examined thousands of them I suppose. I don't mean to say that all of these cases required an operation for the closure of the cervix, but I do mean to say that many of them will be very much benefited by that operation. Where you find the cervix everted, a condition which really occurs, you will find them covered with granulations. If you cannot subdue the granulations by judicious medication, then you must resort to the knife. I have united the laceration by treatment. Sometimes it is a matter of very serious difficulty, at least in my experience, but perhaps I have not acquired the facility that others have. One great difficulty I have found is, that where there is a deposition in the cervix of plastic matter, from the long continuance of the laceration, the edge of the laceration becomes very hard. It is then a very serious difficulty to bring the edges in apposition again. In these cases I have followed the practice of many others; using hot-water injections, long continued. Sometimes I use an application of Iodine and Glycerin, and the Hydrastis preparation. I have followed a suggestion given to me also, in one or two cases, of uniting as soon as possible. First treating it in that way and then securing by pressure, there will be some absorption of this extra tissue, and then you can

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unite the sides. I have found that to be the only way; I have found I could not possibly bring both sides together without closing the os, and this ought not to be done. There are hundreds of cases, I feel assured, where, to all intents and purposes, no operation is necessary. The individual is in perfect health, and only accidentally you find that there is a laceration. I do not believe that all the cases that arise are discovered. Notwithstanding the opinion of these distinguished men, I think that a great many of them will get well without treatment. There are a great many whose condition is as bad after as before the operation.

Dr. Eaton, of Cincinnati: I had supposed that Dr. Biggar was going to give us a paper this afternoon coming out very decidedly in favor of operations upon the cervix for lacerations, but I am agreeably disappointed to find that it is not as urgent upon that point as I had expected. I agree with those who have spoken in reference to this matter. I should say that they have the same mind as myself. We have sometimes found, or imagined that we had found, a great many more lacerations than really were present, or rather more than there was really any necessity for finding. As for the operation that has been recommended, I fail to agree with the gentleman from Toledo, I believe, who says operations are performed much too frequently upon the cervix uteri. I am of the opinion that we should spend the greater portion of our time in discovering how best to prevent these lacerations. I am of the opinion that anæsthetics are very necessary in labor in many instances. I am of the opinion that two-thirds probably of the women should take some anæsthetic during confinement, while in the first stages. This should be given during the dilatation of the os, so that it may become thoroughly dilated before the head comes down. If we take care of that I think we will have very few lacerations. I have been in the habit of using anæsthetics very promptly. That fact should be remembered, for if they are not given promptly we often lose time. I have also used Belladonna ointment to the os; this has been of a great deal of service. I think great attention should be paid to the condition of the os; if it is full and undilated I would give a quarter of a grain of Morphine. You will all understand that, by the administration of Morphine, your pains will be arrested for a short time, but it will do no harm if the case gets a rest for two or three hours. At the end of this time you will generally find that the os will be flattened out, relaxed, and in a favorable condition for the passage of the head. You must not understand me as recommending a powerful dose of Morphine; large doses should not be given, since

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Morphine may hasten abortion. If these pains are not very strong you should give Secale. I will say that I believe one of the most fruitful causes of laceration is allowing the labor to go on before the full completion of the term.

Now there is a point that has not been broached. We are called upon to say how long the labor will last. Suppose we come to the bedside, and look at the patient, and find that the pains are coming with considerable regularity. We do not know whether the woman is at full term or not. If we look and watch we notice that the pains are coming once in about five or ten minutes, and we think it is all right. We give some directions which seem to encourage the progress of the labor, but we do not take the pains to see whether the cervix is dilated or not, and we allow the labor to progress, when, in all probability, the time is not fully accomplished. Probably it is not more than eight or eight and a half months. The cervix then dilates with difficulty, and we force it down, and, perhaps, we give Secale to encourage the pains. We go on until the os is dilated as large as a dollar. We try to dilate it with the finger, or by other means, in order, if possible, to hasten the labor. And the woman labors, and strains, and forces, and after a long time we give Secale, probably in large doses, and then we conclude to use the instruments. All this might be avoided if you would take the pains to find out the condition of the os, and the probable date of the full completion of her time. You should never do these things; I speak now of forcing the labor to come on before the full time. The cause of these pains is from the partial detachment of the placenta, and under some circumstances this may render it necessary that the labor should progress before the full time is accomplished. I can say that in my own experience for the last twenty years, some part of which has been spent in large hospitals, and almost my whole life has been spent among diseases of women, that I have very seldom seen laceration of the cervix which was giving any trouble. I have daily seen cases where there has been a slight laceration of the cervix, which had healed, leaving a slight indentation, interfering in no way with their comfort. The smoothness and rotundity of the cervix, which is naturally the rule, especially where there has been no laceration, are not affected. I do not think that such a case does any harm or needs to be interfered with. I do not think it necessary to stretch a cervix open to discover whether there is a laceration. If a patient comes to you with pain in her back and on the top of her head, and you should go to work with the greatest industry to examine whether there are any lacerations, you might discover some. But I think that

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this thing is carried to excess to-day by some gentlemen. The matter was started by Professor Emmet. It is a very remarkable fact that he has found so many lacerations. Dr. Thomas, practicing by his side, does not find any. We, as gynæcologists, are always accused of finding something the matter in the womb. Lacerations when they do exist are a very serious trouble. I will say that lacerations of the cervix tend to prevent the complete involution of the womb, and this leaves it larger than it should be; leaving it in a sort of partial hypertrophied condition. It also tends to produce hyperplegia of the womb. These two conditions together tend to produce cellulitis. These conditions may produce a sense of bearing down in the pelvis, pain in the back, and the woman may not be in bad health on account of this condition.

Now it has been stated by Dr. Biggar that the uterus should be sustained in position. It is maintained there by its own ligaments. The uterus should be reduced in size and the tenderness should be removed before the operator performs the operation. In other words, you should treat the lady in good health and then go ahead and do the best you can. Now in reference to the arguments that have been made, whether it is necessary to wait until the laceration has been produced. Why not do it a little sooner? Why wait until the woman gives way? I remember a gentleman was telling me not long ago of a case that he found it necessary to operate upon. I inquired into the circumstances of the case. He said he had cured her two or three times and she still relapsed. Whenever she was confined the trouble would return, and this was repeated several times. Finally he concluded it was necessary to operate. He knew that she had laceration, and had had it from the beginning. I told him that I thought it was about time to let her alone, and let her get well by herself. He said he was afraid that she would not return; so in order to make it sure he operated upon her. Now I will tell you the result; the lady did not come back to him any more. She was probably convinced that he had done all he could for her. I think that conservative surgery should be our rule.

Now I want to speak about one of the most ordinary ways of holding up the uterus. The manner in which this is done is apparent when it is described. It should be suspended. When the abdomen is suspended it takes the weight of the bowels off from the uterus. When the tenderness of the os is all gone that is the time to operate; that is what we have been told. But the gentleman omitted to tell us how to put the womb up there and hold it there. That is a very important thing. He

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suggested, however, the use of an elastic pessary; but this could not be used until the sensitiveness of the womb had decreased. It would not do to crowd up a tender womb with an elastic pessary. I think, however, there is something that could be done which is more important than has been said here, or that has been advised. It is of very much more importance than any operation that can be performed upon the cervix. This I have already hinted at. If I know anything about the treatment of diseases of women it is this, that you must take the weight of the bowels off from that tender uterus. By taking off this weight you give the womb a chance to rise in the pelvis, and give it a chance to be relieved of its tenderness, and then by administering the suitable homœopathic remedies you let the woman go in peace and happiness.

Now in regard to lifting up the abdomen; my plan is to hold it up by a suitable abdominal supporter. Not by what Dr. Ludlam calls an abominable supporter, but I mean an abdominal supporter. I do not mean by abdominal pressure, and I think every one should use judgment in the application of the means. I don't care what means you use, but you must so adapt your support that it will secure the end desired; that it holds up the abdomen. I use very frequently a band that has two elastic straps passing around the hips; it is a modification of the London supporter. My idea is that there should be no pressure upon the lower portion. The London supporter compresses the abdomen too high up, and I have had the band made wider in front, and have cut off from the back of the band of the London supporter four or five inches. This improves the supporter. The bands are made of the same material that suspenders are made of. These give great satisfaction when they are worn. You should not crowd the womb up and then push the bowels down upon it, and expect relief. If you do this, you will create inflammation, cellulitis, etc.

S. J. Donaldson, M.D., Portsmouth, N. H.: I have had little personal experience in this matter, only a few cases, but I have been present with Dr. Emmet in a great many cases. One case was quite interesting to me. The patient was under treatment for some time, for some four years she was under my observation, with a severe headache and a feeling as though her head was enveloped in a tight iron band or cap, as she called it, and a sensation as if insects were creeping along the skin. A crawling sensation frequently, as though the hair was tied in a tight knot on the top of her head. Everything was done that could be thought of in the way of administration of remedies. Everything that could be brought to bear was brought to bear

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upon the case. I knew that she had a lacerated cervix, but I did not wish to operate if I could avoid it. She also suffered from half-moon pain, as she described it; this was while she stood on her feet. Finally, after being worried and disappointed in the treatment of the patient, I decided to operate. I operated about four months and a half ago. It was a lateral laceration upon the right side from within out. The operation was very tedious. I took six stitches, using a silver wire. I operated five days after she ceased menstruating. In four days after the operation menstruation set in again, and when I came to examine the stitches I found I had to remove two of the lower ones. To make the story short, since that time she has not had a return of the headache, nor any sign of it. It has now been four months, and she has lost the half-moon pain. There is no dragging sensation in her back, and she appears to be well. I don't know how long it will last, but my idea, in cases of laceration of the cervix, is that it is just like any other wound. You may have a nerve cut, or any wound the cicatrix of which will cause a great deal of reflex action, and you may have a wound and have no pressure and cut no nerve. I think, in this case, there was some nerve or nerves cut in that cicatrix which was very easily detected. This hard substance is, curiously enough, very difficult to remove, but it is very important to remove it. If it is not removed you have no success in your operation. The cicatrix lies in an angle, and the operation is in towards the inner os. I think that if I had failed in removing the hardened mass the operation would have gone for nothing, and the headache would have been just the same. I had another case of severe laceration of the cervix, where there was a great amount of eversion, a turning out of the wound, with no reflex action, no headaches, no troubles to speak of except a leucorrhœal discharge. She has had it for years, for fifteen years; at the age of forty-two she became pregnant again. Since that I have heard no complaint whatever.

R. Ludlam, M.D.: Do I understand you to say that the first patient had not menstruated for four years?

S. J. Donaldson, M.D.: No, sir, I did not make that statement. I said I had attended her for four years. I performed the operation five days after the cessation of the menstruation, and in four days after the operation menstruation returned. I may say I used all the means in my power. I used vaginal injections and cold applications to relieve this irritation and to get the woman in a healthy condition.

Edwin M. Hale, M.D., Chicago: Gentlemen, I do not propose to say anything in regard to the surgical portion of the

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subject. Enough has been said on that point; I think the subject is exhausted. It appears to me, in consonance with some of the other speakers, that we should take into consideration more of the treatment of the morbid conditions attending the laceration. Now I think I have operated a good many times, but I have considered it my function to cure as soon as possible the conditions, and then, if an operation was necessary, to call in a surgeon. I have never been obliged to call in a surgeon but twice in the many, in the good many, cases which I have treated. I wish to say one thing in relation to the proper condition which we find attendant on laceration, and that is in reference to the endometritis. I don't think, in cases of laceration, unless there is endometritis, that they require treatment. If we have inflammation of the inner lining of the womb, which has been termed uterine catarrh, and we have an eversion of the lips and laceration, which is the result of the uterine catarrh, then we should bend our whole energies to treat that condition, and in my experience after treating them successfully, as we can and as we generally do, that in time the lacerations become very much smaller. I have directed my attention to a very great extent to this treatment, so much so that several months after taking a case of laceration, by reducing the endometritis and by reducing the cellular trouble you find the laceration is hardly perceptible, if the laceration is not ended altogether. Now with regard to the means that I have adopted, I will simply say that, if it is a very recent case, one that has occurred within a few months after confinement, and it is an acute case of endometritis, I have generally succeeded with the iodoform pessary. This I have used the last few years. Previous to that time I used the Muriate of hydrastin with excellent success. I applied it in the manner of tents, simple cotton wrapped around a probe. But within the last few years I have used the iodoform pessary, and latterly have incorporated with it the Balsam of Peru, which I think is one of the most wonderful and efficacious remedies that we have for purulent discharges from the mucous tissues. After that inflammation, which gives rise to purulent discharges, has ceased, hot-water injections have been very much used. They should be repeated at first moderately; afterwards they should be used extensively. It was thought that every woman with any uterine trouble, with careful attention, could be cured by the hot-water injection, but it was found after awhile that one-third were injured by the use of the injection. It produced a peculiar kind of pain and a reflex irritation and headache, and in some cases vomiting, and in many cases they did not recover from the irritation, whatever it is, I do not know, for hours afterwards. In this opinion

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I am seconded by two eminent gynæcologists of Chicago, who take the same ground with regard to the supports of the uterus. There must be a conflict of opinion. For my own part I have rejected any outside support for ten years or more, not having used them in a single instance, simply because I find them utterly futile and useless, and the only support which I have used in these cases—I am now speaking of laceration and the eversion of the cervix—is Dr. Jackson's pessary, which is a soft rubber or wire bent in a proper shape to fit the vagina. I have also used Thomas's improvement on A. H. Smith's pessary, but I much prefer Jackson's for many reasons. In the first place it is soft; there is no hard pressure on the vagina and uterus. In the next place you can bend it into any shape you please. Some man, speaking before the Massachusetts State Society, advanced the idea that any number and size or shapes of pessaries could be used. That man certainly was very deficient in anatomical knowledge, because there is just as much difference in vaginas and uteri as there is in noses. You cannot pick out any one pessary and say, this will fit four vaginas out of five in prolapsus uteri. The fact is, that the fitting of a pessary is very much like the fitting of a shoe. You had better have it made for you, and so with the pessary. It has got to be bent for each particular case. You remember very well, those of you who have read Thomas's work, that a gentleman—a physician—came in with some newfangled idea in reference to a pessary, and he said to him: "This, doctor, will suit nine-tenths of all the cases." Dr. Thomas said he then actually showed him a barrelful of pessaries and told him: "If you will find two of the same size and shape in that barrel I will adopt your pessary as the only universal pessary." Of course that finished the matter. There is another thing, unless you do support the uterus, and while you are supporting it use your local or general treatment, you will not have much success. The tendency, as Dr. Walker has stated, is for the abdominal contents of the bowels to press upon the uterus. There is a constant tendency to an eversion of the lips, and so long as you cannot prevent that eversion of the lining membrane you cannot do the case any good whatever. There is another practice which it is worth while to adopt, and of which you might have a hint from the confusion in the old-school practice. You are well aware that in using Chromic acid and Nitrate of silver as much as they do they produce constrictions of the os and contractions of the cervix, which afterwards require a great deal of treatment and cause a great deal of trouble. Now in many cases of eversion of the lips, not very bad, after getting a proper support for the uterus, if you

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touch it with Chromic acid, beginning very lightly on the everted portion and increasing in strength, you will observe the everted portions gradually approach each other in consequence of the contraction of the tissue caused by the contractile power of the Chromic acid. The same may be said of the Nitrate of silver, but not to such an extent. Another simple method is to apply on cotton tampons the healing preparation. I think that some member of this Society reported four or five successful cases which were cured by cotton saturated by Tannate of glycerin. This subdued the acute disease and produced contraction, which is just what we want. I would say, I would appeal to all who are nominally homœopaths, to try every constitutional measure, and every rational medical measure, before they send a case to an operator to be operated upon.

Dr. O. S. Runnells: I think, if there is any one thing apparent here this afternoon, it is the great diversity of opinion that has been manifested. Now it would be proper to know why we have so much diversity. I have been thinking about it. In the first place, this is a new thing in medicine and in surgery. It was only as early as 1862 when the thought first flashed across the brain of Dr. Emmet that possibly the laceration of the cervix uteri had a good deal to do with many of these disturbances among ladies. He had no data then to formulate a proposition upon. But after years of experience and of earnest labor and effort, in 1869 he broached the subject professionally in a short paper on the surgery of the cervix, merely hinting, but not enough to allow the profession to grasp the idea at all. It was not until the year 1874, in the month of November, that he published his first paper on the lacerations of the cervix uteri; that was a little more than five years ago. Since then the subject has been considerably more developed. Our knowledge, then, of this subject has been gained within five years. Now you all know that is a very brief time in which to teach us any scientific subject, a very brief time indeed, and it is not strange, I say, that we should have this diversity of opinion. Now going back only a few years, we have noticed among men of learning and ability on this subject a great diversity of opinion. There is also the same thing to be found if you go back three-quarters of a century and take any subject. I say it is a remarkable thing that so many are now found to advocate this measure after it has been proposed.

About the frequency of the occurrence of this accident I have no question. I think the figures given will be found, upon careful investigation, to be sustained. Dr. Mundé, of New York, said that, of the ladies appearing in his clinic, seventeen per cent.

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had lacerations; Dr. Bull says it is fully forty per cent. of all those suffering, while Dr. Mundé says, of all the ladies who have come to him for treatment, who have been impregnated, 33 per cent. have this laceration. Now, as Dr. Walker, of St. Louis, has said, while we have not found them I do not doubt but that they are there. Now the question is, why have we not found them? Because we have not been looking for them, because we have not been versed in the methods of observation. The ordinary speculum is not adapted for this purpose; the limbs of the speculum, as they diverge, put the field of observation on the stretch, and the object aimed at is defeated in the majority of instances. It is only when you use a perineal contractor of some form, and those made according to the principle of Dr. Sims are the best, that you find traces of this accident.

Now what has been said about preventing this accident is all very well indeed; we should by all means prevent this if it is possible. But I hold, sir, that there are cases in which it is impossible to prevent it, just the same as it is impossible to prevent laceration of the perinæum in every instance. We all know that, in some cases, the perinæum will rupture in some persons under the most favorable conditions; it matters not who is at the breech. So it is here; sometimes you have laceration of a necessity, and then the question arises, What are you going to do with it when it does occur? It is very evident that you must use the best method to bring about the best results; to do so it is necessary to know when you have laceration—to know early, as early as possible. I have been thinking on this subject a great deal of late, and I have come to the conclusion that it is one of the most frightful evils in all the domain of gynæcology. I think the best results will be obtained, in many of these so-called incurable cases, by physicians who investigate this subject—I mean cases that have gone from one physician to another and have failed to be benefited. I think that good results will be obtained often by paying attention to this matter, and by finding out whether this accident has occurred and whether or not it is the cause of all the trouble. I say when laceration has occurred in these cases of labor of which the doctor spoke, where the uterine contraction is firm, and where hæmorrhage exists, where post-partum hæmorrhage exists, and where there are other severe symptoms, you then may be assured that this hæmorrhage could not occur from the placenta itself; it must have occurred from some other source along the uterine surface, or from some point of abrasion in the vagina. If you make an examination it can be easily determined by the sense of touch or by inspection; this should always be done; no case should be left of that kind without a

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knowledge on the part of the physician of the whole condition of affairs. If then it is not from a ruptured perinæum it must be from one of these sources. Great attention should be paid to this thing; no one should rest assured without positive knowledge as to whether laceration has occurred, for trouble will sometimes come on with the most serious results from that condition. You might as well talk, I think, about bringing together the opposing surfaces of harelip with a remedy as to talk about healing the torn and bleeding surfaces of the cervix with a remedy, and that an internal remedy of a high potency. I think we do our cause harm by claiming for it things that are impossible. I say we ought to grapple with this subject, and try to get the best results possible. When we have a case that is brought to us of a lady who has suffered for years with neuralgia, and pains in every part of the body, one who has sought relief from the hands of the practitioners of almost every school of medicine, then I say it devolves upon the man who is consulted to find out what the matter is, and to diagnose that case, if it has never been diagnosed before, and then to make up a rational diagnosis and cure the case. We should take up the case and settle the matter. Gentlemen, if you do this and settle it correctly I think that, in many cases, you will find a lacerated cervix is at the bottom of all this trouble; depend upon it that this is the case. If you succeed you will open the door to a brilliant success. I have had some experience in this matter, and I do not want to advocate the means here that will not redound to your own great satisfaction in your practice, but I do believe, when this matter is thoroughly investigated, and these cases are thoroughly investigated, you will be satisfied to the utmost in your success in curing them.

There is one point I wish to speak about which has been referred to by Dr. Walker, and that is, the knee and elbow position in the operation. I think in many of these cases you will find it a difficult matter to bring the cervix to the vulva in order to secure the operation on the os; at least I found it so in a case that I had where the abdominal contents had fallen down, and so retracted the cervix from the vulva that I was unable to perform the operation in that way, and I put the patient into the left lateral semi-prone position.

I would say that, from the experience I have had with this method, and it is not extensive,—I have had but three cases, and I have operated upon two of them. When they come to you with these cases they really believe that they must be operated upon, and before they come they will have gone, some of them, for ten years. They are great sufferers in this disease, but I believe

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they can be thoroughly cured in a short time. As I have said, I have had three cases, and in these cases the result has been such as to make me enthusiastic. One of the patients that I had went five years, and suffered all the time; the other had been a sufferer for eight years. As soon as the laceration was cured she became pregnant. It has now been six months since the operation.

Dr. L. A. Bishop, of Fond du Lac: This is a subject that has interested me very much indeed for the last year. It has interested me so much that I have left the meeting of my choice, which is upon the subject of ophthalmology and otology, and have come up here to listen to this discussion. There has been no subject in the domain of medicine that I really felt that I was so ignorant upon as I was upon the subject of diseases of the cervix. I could not have believed it when I had cases every day to look after, up to these last few years. I can now see cases of laceration of the cervix that I did not recognize as anything of the kind at all, because I was ignorant.

Now there is one subject and one idea that has been brought forward, and that is this, the proportion of these cases. It has only been within the last two years that any special attention has been given to that subject. We have to treat cases all the way from 18 to 75 years of age. Now it may be, and the idea has not been suggested by any of the physicians present, that this 33 per cent. may have covered that whole line of fifty years; these cases may all of them have occurred a good many years back. We cannot get at the correct statistics of this matter until a number of years have passed by. We are all of us now examining cases which may have occurred ten or twenty or five years ago, or two months ago; it is difficult to say when they did occur. It seems to me that a conservative rational standpoint is the standpoint to take, as has just been done by the gentleman who preceded me. Supposing the mucous membrane only is lacerated, and the muscular tissues are intact, then, by proper treatment, I can readily see how that case can be permanently cured; but where the muscular tissues are divided I see no reason why cases should be cured; I see no reason that cases should not be cured where they are not divided, as well in the perinæum as elsewhere. I cannot see any reason why the abrasion of the mucous surface cannot be cured as well if there is a wound of the muscular structure; I can see no reason why that cannot be cured and healed up. These tissues may be drawn up together, and be entirely healed over. But we might just as well think of doing an impossibility as to think of curing with medicine that which requires the services of the knife. It cannot be done; abnormal

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growths, hardened tissues, must be removed with the knife; they cannot be cured in any other way scientifically. If they are cured by the scientific use of the knife they will never trouble you or anybody else again, and that is just the light in which I look upon lacerations of the cervix. I had some little experience in them during the last year, and I look back on my previous experience and can scarcely realize how stupid I have been. I have really been an ignoramus upon that point, where in other places I would not hesitate to operate, nor hesitate to bring the surfaces together and unite them with a suture. Why we should not use the same means in this condition of the cervix is a great question to me. Why that should be an exception, and why the cervix can tolerate being put in a different position and left out of position,—to say that we have no right to put them back into position, that it is not practicable to put them back there and to hold them there,—seems to be an anomaly. There are cases that I have seen, and which have come under my observation, where two weeks' treatment or three weeks' treatment, watching the same as you would that of any other operation, will do more than you have been able to do in six months of medication. Why it seems to me that it would be folly to talk of treating such a case for six months, since if it is only for your fee you can charge enough for your operation to cover that. It seems to me to be folly to entertain any such idea. I can readily see many cases that I think could be treated by medical means, by an internal remedy, and which could get along nicely, but they are not such cases as we have when we have laceration of the muscular tissue, with destruction of tissue or the interruption of the continuity of it, with a special effect upon the system. There are many cases that local remedies will not cure any more than they could right an eyelid that is turned wrong side up.

R. Ludlam, M.D.: I see that you will have my speeches whether I am in the chair or not. I have but a few words to offer on this subject. I would like to say something concerning the prophylaxis of this operation. I believe one of the most natural and necessary safeguards against resulting chronic laceration of the cervix following labor is to keep the patient quiet in bed until the lacerations have healed spontaneously. I believe that the exemption which our mothers and grandmothers had from these lesions was due to the fact, in large part, that the doctors had power and sense enough to keep the woman quiet in bed for the first nine days, or the first two or three weeks, if necessary, after the delivery of the infant. Nothing will so interrupt the healing process in these little lacerations. Where, as a rule, we find them in every case of labor, no matter whether

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the child is born naturally or not, nothing is such a promoter of the healing of these lesions as keeping the patient quiet, and keeping the parts clean. Moreover, I believe that if Calendula is used locally and freely at the same time, a very great proportion of the smaller lacerations will certainly be healed up and the woman will be put upon her feet again. I honestly think the profession is largely responsible for the many lacerations which have resulted, because they do not take care of the woman after childbirth. The best thing to use is Calendula with glycerin. That is the best antiseptic that can be used in such a state. It should be used very freely. It is very healing indeed, and if the suppuration is copious and free, I use it internally at the same time for the same object. So much for the prophylaxis. I believe that what I have said in reference to the healing of these lacerations after labor at term, is just as important in cases of abortion. In cases of abortion at the sixth week, and from that time on, lacerations do certainly occur. At that time I think, and I believe, they will heal and the bad effects of their occurrence will be taken away from the profession. As it is we have a large share of these cases entailed upon us at present, and all we have to do is to cure them, giving the patients good advice and telling them to look out in future. I think it is very lucky for us that we have been ignorant of this matter for so long, as the result might have been different. I certainly think that we need to go down on our knees, some of us, when we think of some of these lesions connected with the laceration of the cervix. They are just as difficult to understand as chronic diseases, or chronic sore throat, in conjunction with pelvic cellulitis, and this is a very frequent complication, and we have ectropion of the cervix; this term is applied to the eye, it is also applied to eversion of the cervical mucous membrane. Ectropion of the cervix is a condition that is very difficult to cure. There is great inconvenience and trouble when this accident is not properly cured, and when the lacerations are not healed. But I do not see how my friend Dr. Biggar could recommend that the uterus should be reduced in size and weight and then go on with the operation. It will be difficult to reduce the size of the womb when its width is four or five inches, as is very often the case, I think, where there is laceration.

As to the suggestion of Dr. Walker that some cases can be operated upon in the knee-elbow position, I believe he is right. I would like to suggest in reference to the use of the anæsthetic, that there must be great difficulty in breathing in that position. As for the remarks of my friend Dr. Allen, of Detroit, in reference to the use of the forceps, I thought that was a

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little unkind towards the instrument, as the instrument is a very useful one, and of late years has not done as much mischief as it formerly did. It is one of the most harmless and most useful instruments when properly employed that we can possibly think of. I think that the charge cannot be laid at the door of the forceps that it causes laceration, especially nowadays, as I think all of us know pretty well how to use the forceps and save the operations, rather than to cause them. If we do not, it is not the fault of my friend, who has taught obstetrics for twenty years, and has been teaching these boys and girls how to use this instrument without doing harm.

As for the information that my friend Parsons wants, I think that I can furnish it in a few words. He wants to know why laceration of the cervix should not heal just as readily as any other wound. I think that when we remember that these lacerations come to us after years have elapsed, it will be easy enough to suggest and to conclude that such a laceration would not grow together any more than a wound of the finger, because the edges of the wound are covered over with mucous membrane. That mucous membrane must be removed and freshened before the edges would unite at all. If you would draw them together they would not unite. It is not a parallel case with a fresh flesh-wound by any means.

I think that this subject has been very well ventilated, and before I call upon Dr. Biggar to close the discussion of the bureau, I would remind you that we have spent two hours, I believe profitably and very profitably, with an audience of over one hundred physicians in attendance, showing the interest that is taken in the discussions of the practical questions and the discussions that come in as a part of this bureau. As the father or mother, I don't know which, of this sectional department of the Institute, I have spent considerable time personally in the success of this bureau, in the success of this sectional department of the Institute. I believe that all our work ought to be done in sections, and then we could sit and talk about the papers that are brought up as they are this afternoon.

Dr. Walker: I wish to set myself right before the physicians here assembled, and also that of many others, that those who have not operated, and those who have no interest in the operation, those who are not in the habit of doing it very frequently, will not have the idea that it is not sometimes necessary. When patients present themselves to me for the first time, I investigate the case, I write down the symptoms and seek out the homœopathic remedy and treat that as such for a time, and if I fail then I make an examination and find out what the

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trouble is, if possible, and when I have found it out, if I find out that we have a laceration that I don't believe can be cured by medicine then I resort to surgical treatment. That is what I wish to explain. My first attempt is to try and cure by medical applications. If I do not succeed, I resort to surgical interference. If the laceration is an extensive one, and there is ectropion of the os, why then that is a case for an operation. Now as to the frequency of the operation. From all that has been said here, the number of cases related of laceration of the cervix, taking them all together now, I do not believe that we have seen twenty-five cases, the whole of us here. Now these twenty-five cases, out of the thousand of cases treated, is a small percentage, for here are men who have treated thousands and thousands of women, and yet the whole of us have not seen as many as twenty-five cases all together. We have not seen more. I have treated a great many women, but I have not seen more than half a dozen that I thought would need an operation. These two that I spoke of were in the hospital. I might here state that the one who was cured, previous to treatment, could not go up and downstairs, but now she does the work in the hospital, and she is perfectly well. There is now no difficulty about going up and down stairs.

The forceps have been alluded to and been thought to be a cause of the many lacerations, but I will tell you that the forceps is the best instrument ever invented for the relief of woman, and if used prudently does good instead of harm. They relieve many a woman of accidents which would have happened, and from which she would never have recovered during the whole course of her life. Laceration of the perinæum and of the rectum have been prevented by the use of this instrument. I remember a case that I saw where there was no instrument used, and where the head laid in the part until sphacelus had commenced; and so, probably, it is in regard to the cervix probably.

Now of the many persons that I have attended I cannot tell whether there were lacerations or not, because my attention has never been called to it, the women have never come to me and talked to me about it and requested an examination, consequently I could not tell. There may have been lacerations and I did not know about them; but of those I have seen and examined, I may say about one in thirty, with laceration after labor, need an operation before they are cured.

Now all know that Dr. Emmet commenced these investigations first; he was an enthusiast. Now enthusiasts are necessary, just as necessary as it is to have pioneers; as necessary as it is to have men to go out into the wilderness and fit it for civi-

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lization. You think a man who does that is a fool, but he leads the way for others to follow. He shows to us the way in which we can go after awhile. While there are extremes in everything, I think that they are just as necessary as those who are conservative. They are just like the skirmishers in the army, they are here and there, they do not do much good, and when they get into trouble they fall back on the main line, which is the real strength of the army, but still they are necessary. After all the strength of the army lies in the main body; so I say enthusiasts in medicine are of just the same use. I put in that claim for Dr. Emmet, although I do not believe half he says about it. I think he is an enthusiast; he keeps his mind on it and sees things that he would not otherwise see.

Now there is another point in regard to the prophylaxis which has not been touched that I remember, I refer to the subject of diet. I claim that a fruit diet for the woman will relieve her of many lacerations of the cervix and the perinæum. Keep the woman from eating a crude diet, cracked wheat, oatmeal, and all of that kind of provision, in which we have an excess of earthy matter. Nothing that makes bone should be given. These things make the child's head hard. She should be kept from eating these things as much as possible. Besides that you should keep her from eating meat, which makes the muscles hard. In other words, do not feed her as you would a man who eats meat, and has hard muscles, and takes regular exercise.

R. LUDLAM, M.D.: What if she is going to do hard work and wants muscle?

DR. WALKER: If you wish an easy labor you must give the woman a fruit diet. I am speaking now generally. I know the laboring people need a different diet, that is the men, and I also know that five out of six of these Irish women have to work for a living. They eat the crudest kind of food, the men do, and the women feed in the same way. Some of the women have to do more work unfortunately. They go to the other extreme, but I claim that some women do not work enough, and that others work too much. If more of the women would work for their living we would be better off, and none would have to work too much. I have a woman in my mind who was robust, red-faced, and strong, she could do just as much as any man could, but she was not obliged to work. Now she was pregnant with her first child and she was in good health, in better health than she had ever been. She ate roast beef and kept her stomach full, she took exercise regularly, and went out to walk, and this increased her appetite, and she imagined that she was going to have a glorious time. I did not know then what I know now, or I

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could have advised her. Now when that woman came to the end of pregnancy she had the worst labor I ever saw any woman have. That could not have been unless there was something wrong, but it was a regular labor and it was the biggest child I ever saw. The child weighed 14 pounds. I have heard of children weighing 15, 16, and 17 pounds, but I never saw them. I weighed this child twice, because I thought it weighed more. I weighed it in two different scales. It weighed just 14 pounds. Its head was hard, there was no give to it. It nearly killed the woman. The consequence was she would never have another baby, and she never did have another one since, and I do not blame her.

Dr. Breyfogle: I simply want to ask a question as to the operation, whether in operating for laceration if the edges are brought together and a rubber band is placed over the os there is any necessity for sutures? Whether a strong rubber band, if it did not produce too much pressure, would not answer the purpose of the sutures? This could be put on and there would be no necessity for using chloroform, and for so many assistants, and would almost entirely remove the pain in many instances. I wish to inquire whether any physician has had any experience with them, and what objection there could be to their use?

C. H. Von Tagen, M.D.: I think I can make a few remarks on that subject that will throw some light on the result. I have not exactly used the rubber band in this trouble, but I have used it as an agent for compressing other portions of the body, to keep the parts in apposition, as well as to get rid of induration by absorption. Hoping to do so by general pressure, but with the most carefully selected article and the most delicate that would bear tension, I have found, even if put on other parts of the body, the patient will complain of the pain. It seems to interfere with the circulation, and acts as a ligature. If it is placed upon the neck it constricts the parts and prevents the free flow of the blood, and it sets up an irritation by its presence and does more harm than benefit. I therefore presume that it would act much in the same way upon the cervix uteri.

I would like to make a few remarks upon the subject of prophylaxis; when I was speaking before it did not enter my mind. If it is agreeable to the gentlemen present, and with the permission of the President, I would like to make a few remarks upon the subject of prophylaxis.

In reference to prophylaxis there is one thing that has been overlooked, and I have not heard it explained, and that is the affection of the spine. When I was in general practice in the city of Harrisburg I had a very large obstetrical practice there,

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and the number of cases treated between myself and partner numbered upwards of 300 cases or more a year. I invariably found in every case of labor that the patient suffered more or less with the spine, and upon examining that structure I found an absence of what we might call symmetry; a loss of symmetry of the part.

Now if you take a look at the spine, and if you remember how the spine in its natural state curves, and how common a thing it is for women to get into a crouching attitude, you will see and realize how the spine will, after years, finally take on that peculiar shape. This attitude is very common with girls that go to school. I have frequently cured uterine trouble in girls and falling of the womb, and there is no doubt in my mind, after a careful examination of a large number of cases, and in thinking over the matter a great deal, that the prime condition that gives rise to endometritis, in a great many cases, is first the displacement of the organs, and then the crowding down of the abdominal contents, which was referred to at length by one of the gentlemen. In all these cases there is loss of spinal symmetry. Now if you restore that spinal symmetry you lift the weight off from the organ and help to replace it gradually. If you pay attention to that part of the treatment you will get good results. I frequently cure cases in that way without any other additional or local application.

Probably the Calendula is the best remedy that can be used. That has been the favorite remedy, and, as Professor Ludlam has referred to an apparatus, I would say that the apparatus I selected for that purpose was Banning's spinal and abdominal supporter, without the uterine support; I found the latter an abomination and discarded it. It consists of a light steel support for the back, with a shoulderpiece, which throws the shoulders back and gives support to the lumbar region, which is the point they always refer their sufferings to. They all complain of pain there. You restore the symmetry of the spine with the abdominal portion, consisting of a shell pad, which may be covered with some soft material, and which supports the abdominal contents the same as if your hands were placed there, while attached to this abdominal pad is a light steel spring, built on the principle of a carriage spring, so that when the patient breathes the pad is allowed to play to and fro.

I also received an idea from an article that I once read, written by Dr. Chapman, of London, who accounts for the tenderness of the spine in a very clear manner. He states that the spinal centres and the spinal ganglia are all more or less found in a state of congestion. They are surrounded, as we know, by

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an assemblage of bloodvessels which become surcharged with blood, and the pressure on these ganglia produces the weakness of the muscles, giving that increase to the bending forward and the crouching down. When this condition is relieved many cases are cured.

H. F. Biggar, M.D.: This subject has elicited a good many opinions with which I am most delighted. I have been very greatly instructed. This subject was introduced for the purpose of instruction. There were a few questions asked which have not been answered. These have been left, perhaps, for me to answer. I will say in regard to the position, that if the person chooses he may first use the position as Bozeman uses it in the operation for vesico-vaginal fistula. Though I think there is greater danger on the chest than on the back, and greater danger to the patient upon the left side than upon the back, for the reason that you want to keep the breathing apparatus as free as possible from compression. If you put the patient upon the side there will be more compression than on the back, and if on the face, more than on the back, unless it is protected as Bozeman does; he does this to a certain extent but not sufficiently. It is not as safe as on the back, consequently it is not as good a position. The position on the left side is better adapted to getting at the organ upon which we want to operate. What we want to avoid is producing irritation, which produces pelvic cellulitis.

In regard to elongated cervix I made a statement. It was said to you—the statement is given by Dr. Emmet—that it was not necessary to operate upon the elongated cervix, because he always found it was the result of laceration of the cervix. Dr. Allen asked me in regard to that. He said we find it in the virgin. We do not find it in the virgin. I have never found it yet in a virgin; it only occurs as a result of impregnation.

Now the question comes up, when is it necessary to operate? It is not necessary in all cases by any means. You have the prophylactic remedies; you can give them. In regard to Calendula, I would say that it is a most excellent remedy. There are other things to be taken into consideration before the birth of the child. And in this connection it is well to remember the preventive measures suggested by Mrs. Dr. Cook.

We know the most prevailing thing which produces this is a tedious labor. The next thing is a rapid labor. Then we have the turning of the child and the use of the forceps. Criminal abortion is also a cause which produces this. Of course, if you can prevent these things, you will prevent having a lacerated cervix to a very great extent.

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Now in regard to the hare-lip sutures—hair, I should say. I will say this, that there are some hopes for us. We can use the suture with as much accuracy, and as much assurance, as we can in the operations upon the ear. For instance, you take an organ like the uterus, where the pelvis is much contracted, and the uterus is at the bottom of the well as it were, the question will arise as to what sutures you will use. Of course the most convenient are the best to use, taking into consideration the results produced. Where you have a uterus well up in a narrow contracted pelvis, with a small vaginal canal, you cannot get at that uterus very well. Now in order to operate away up there, out of reach as it were, quite in the dark, in that narrow space, you will find it impossible to tie with the hair suture. It cannot be done as easily as you can twist the wire suture. I think this should be taken into consideration, especially if you want to get union by the first intention.

Now in regard to the hot water which Dr. Hall has suggested, I fully agree with him. I think that it is too frequently used. I think you can get better results by using the tampon with water and glycerated tannin. You can also use Tannic acid as an astringent, and keep them in place much better. Hot water is much better than Calendula. You are justified in using it.

Now in regard to reducing the size of the uterus and in regard to the displacements that we find, the first thing to be done is to right the displacement. If the woman is discouraged, you have a right to use the tampon, and if you choose the Glycerin and Tannic acid, or any other means which may be at your service or which you are accustomed to use in reducing the size of the uterus. First, then, you have to remedy and restore it to its natural position.

Then in reference to the use of the pessary, I will say what I forgot to say in my remarks in the paper, that you must not use a soft-rubber pessary of too large a size. You must use it of the same size. It is not for the purpose of enlarging the vaginal canal, but it is for a support. It should not be too large, or suppuration will be produced, and the pessary will denude the cervix and irritate it, and you will have a bad leucorrhœal discharge. You want a pessary which will act as a curative and not as a destructive agent. If it does its work well, it is a good thing. You can guard against excessive discharge by carbolated water or calendulated water.

Now, as to this operation, I will say that there is no difficulty about it. It requires no undue skill. Any person can do it, as far as my observation goes in the few operations that I have attended. It heals nicely and the woman is generally benefited.

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When necessary to operate this is the case. But in many instances it is not necessary to operate, and you can heal up and rectify the condition of things in many ways. Dr. Eaton suggests, for instance, an abdominal support. I have not spoken of adjuvants. But you may take them into consideration. You should regulate the diet of the patient, and look to the hygienic measures, and do everything that will bring up the health of the patient and relieve the parts.

There is one cause for this which has not been mentioned, with which I will close what I have to say, and that is this,—that as obstetricians and as physicians, and I will say it for the benefit of the obstetrical portion, that sometimes we are apt to be in a hurry, and when we are called to a case of labor and find the membranes protruding, we rupture the membranes and allow the escape of the amniotic fluid, which is the natural wedge for dilating the cervical canal, and the risk of a rupture, in my estimation, is greater. This is owing to the rupture of these membranes, which is regarded by some as unnecessary. I take stronger ground, I think it is entirely unwarrantable.

E. M. Hale, M.D.: I wish to make two corrections, and that is to say that one case was cured and the other merely relieved by the tampon. It was Dr. Dorris, of Fond du Lac, and it was Dr. Emmet but not Dr. Dorris who used the pessaries.

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REPORT

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ACUTE INTUSSUSCEPTION.

By N. Schneider, M.D., Cleveland, O.

I have no doubt but that invagination of the bowel takes place, and is restored, without producing serious results, more often than is suspected, since it is impossible to diagnose intussusception unless strangulation takes place. It may exist for an indefinite time without cutting off the circulation or the calibre of the bowel, the same as hernia may exist without strangulation or even producing much discomfort.

There are two varieties of intussusception recognized after death, one wherein there are no signs of irritation, which is supposed to take place during the death-struggle or after death, the other marked by signs of severe irritation and inflammation, which must have existed prior to death. It is with the latter we have to deal.

In order to comprehend the symptoms and pathology of intussusception we must understand the very interesting and important anatomical relations. The part implicated is composed of three folds of the intestines, the outer one as the sheath, the middle one as the entering layer, the inner one as the returning layer. The outer and middle layers oppose their mucous surfaces, the middle and inner ones their peritoneal surfaces, while between the middle and inner layers lies the mesentery, which, as the invagination increases, is put upon a stretch, and becomes a round cord, or nearly so, or, as some one has said, a triangle with its apex attached to the lower angle of the invagination. The tension induced by this mesentery draws upon the invaginated mass and gives it a curved appearance, its convex surface being opposite the attachment of the mesentery.

Intussusception may take place anywhere along the intestinal

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canal, but most often occurs at the junction of the ileum and cæcum; it is frequently found at the sigmoid flexure.

It occurs more frequently in children than in adults, statistics showing that over fifty per cent. occurs during the first ten years. It occurs more often in males than in females.

It frequently follows debilitating diarrhœa, dysentery, polypoid tumors of the bowels, etc. It is supposed to depend upon an arrest of the peristaltic action of that portion first invaginated.

There are many theories as to the cause, but as far as therapeutics are concerned it is enough to know that, from some cause, be it local irritation or morbific force, the peristaltic action has been interfered with.

The symptoms of invagination may come on gradually, by an attack of slight colic preceded by some accidental cause, then pass away and return again, and so continue for days, until, either from peritoneal irritation or compression of the invaginated mesentery or obstruction, they declare themselves with great violence. We have intense colic, at first circumscribed, which is frequently relieved by pressure, but it soon spreads over the whole abdomen. The pain intermits, leaving the patient free, but during the intermission the patient is prostrated and weak. The pain soon returns with great violence, attended with vomiting, which becomes intense and distressing. At first the matter vomited is the contents of the stomach, then quantities of bilious matter; the latter continues until fecal matter may be ejected, depending upon the situation of the obstruction. The abdomen becomes distended, tender, and tympanitic. There is a painful urging to stool, which is accompanied by a discharge of bloody mucus, with more or less tenesmus. This is pathognomonic of intussusception, but must not be confounded with dysentery. Unless relieved these symptoms continue, and the condition becomes more critical. The patient has cold extremities, cold sweats, sunken eyes, extreme prostration, great thirst, hiccoughs, dyspnœa, hoarse muffled voice, dirty brown tongue, in fact all the symptoms of extreme collapse.

The physician has done all he can; his Materia Medica has been faithfully studied and skilfully applied; all his efforts are baffled. The surgeon's aid is now demanded at a time when na-

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ture is so exhausted, as to exclude all hope of success; when the tissues involved have undergone such pathological changes as to preclude any expectation that the powers of nature are sufficient to effect a cure, no matter in how favorable a position the surgeon by his skilful operation may place them. The various pathological conditions which give rise to acute obstruction of the bowel present a train of symptoms not unlike the foregoing. But the differential symptoms are the history of the attack, the extreme constipation and inability to pass flatus. In obstructions from hernia, knotting or bands, the pain is circumscribed and continues from first to last; while in intussusception the attack is attended by a bloody mucous diarrhœa, the pain is intermitting and becomes diffused, relieved by pressure. While we can sometimes detect a distended coil of intestine, in knotting or bands, we can frequently feel in intussusception a distinct tumor. Dr. Leichtenstein says: "When a tumor is recognized in the epigastric region, the ileum is the part invaginated; when in the right iliac fossa, the ileum into the cæcum; and when it can be felt in the rectum, it is the colon. A blood-clot in the rectum must not be mistaken for an invaginated bowel."

The treatment of intussusception is a question of great interest. Whether the administration of medicine has any salutary influence or not, other than to alleviate suffering, no one can assert. But I do imagine that there are many cases of severe and obstinate colic, attended with great prostration, produced by a disturbed peristaltic action, which would pass into intussusception, were it not for the prompt administration of indicated remedies; but when the pathological changes are so far advanced as to produce the pathognomonic symptoms by which we can positively diagnose intussusception, I have no faith that any drug will so influence the case as to restore the parts to the normal condition. I believe, however, that the symptoms may be so modified and pathological changes so limited by the administration of properly selected remedies, that time may be given for more decided surgical interference. Cathartics and drastic drugs should never be administered; they hasten a fatal termination.

Among the remedies bearing the similimum Colocynth stands in bold relief, and its clinical history does not belie its

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pathogenesis. Second to it stands Dioscorea vil., having its action upon the nerve centres which preside over the chylopoietic system. It promptly relieves many symptoms which indicate invagination. I have no doubt it has relieved many a case which would have passed beyond the pale of therapeutics. Nux v., Opium, and Veratrum alb., are remedies which claim an important place in our armamentarium.

If the indicated remedy fails the patient should be put under full doses of Opium sufficient to quiet the peristaltic action of the bowels, which prevents an increased invagination; it also relieves the tenesmus, alleviates the pain, and saves the patient from the severe exhaustion incident to the suffering. Attempts should now be made to reduce the invagination by injecting warm water and air; the bowel should be relieved of all fecal matter below the invagination by an enema of suds and oil, before an attempt is made with a force syringe or bellows. A flexible tube may be carried up the bowel per rectum and air or water forced through this.

Great care should be exercised, as rough and forcible handling will do much harm.

If there are signs of gangrene and extensive peritonitis, all efforts will hasten an unfavorable termination.

Should the efforts be unsuccessful, we must now consider the more serious operation of opening the abdomen, laparotomy. I will here urge the necessity of making the operation early in the case, as soon as the more common methods have been tested, before any of the fatal symptoms declare themselves. It is true that the clinical history so far is not favorable; but it is as true, that the pathological changes have been such as to preclude a favorable result. I have no doubt should the operation be made before the strangulation becomes complete, or general peritonitis established and the system exhausted, it would be comparatively successful, and many a valuable life be saved. It is true that adhesions of the opposed peritoneal surfaces take place very early in the disease, and may become a barrier to reduction after the condition has been found, yet there are cases on record wherein positive symptoms had existed for days and been relieved by an operation.

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Hutchins, of London, records a case where he drew out an invaginated bowel of thirty days' standing.

Howard Marsh, of London, records a case of successful issue of fourteen days' duration, while H. B. Sands, of New York, reports a successful case eighteen hours after the appearance of positive symptoms.

I have made three post-mortems, where the person died in extreme collapse, with extensive peritonitis and gangrene of the bowel, where there were no adhesions of peritoneal surfaces, and the invaginated bowel was readily restored.

It is not necessary to describe the operation, as extensive rules are given in most books on general surgery. Suffice it to say that great care should be exercised in handling the congested bowel, and perhaps already inflamed peritoneum.

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ACUTE PERITONITIS IN ITS RELATION TO THE DIAGNOSIS AND SURGICAL TREATMENT OF DISEASES OF THE ABDOMINAL VISCERA.

By John C. Minor, M.D., New York.

In the surgery of the abdomen no one condition occupies so prominent a position, in its relation to all operative measures, as the inflammatory process attacking the peritoneum. It is not merely the intrinsic danger of peritonitis itself that commands attention, its most important feature, from a clinical point of view, lies in its action as a complication. In considering its relation to the diagnosis and surgical treatment of diseases of the abdominal viscera we have an opportunity for a clinical survey extending over a wider field than could easily be found in the more methodical study of the special diseases which will follow, and this will explain why the more systematic arrangement has been abandoned in order to preserve the clinical aspect of our topic.

I. Acute peritonitis is a strongly marked disease. The symptoms are all of a high grade, attracting attention at once by their severity and definite character. Considered alone it would seem impossible to mistake a condition so sharply outlined in all its clinical features, and yet in actual practice no disease has been so fruitful in fatal mistakes in diagnosis and treatment.

In a large majority of cases the mistake has been committed not by a failure to recognize acute peritonitis, but from not appreciating the fact that acute peritonitis is rarely, if ever, an idio-

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pathic disease. There is in most cases an antecedent trouble, a primary affection, whose symptoms are hidden perhaps by the more prominent features of the peritoneal inflammation; and the importance of peritonitis as a complication may be appreciated when we consider the fact that in most of these fatal cases, it is the primary trouble that kills the patient. From a pathological standpoint this is not strictly true; but, considering the cases from a clinical point of view, and particularly with reference to surgical treatment, it is safe to assume that a large majority of fatal cases of peritonitis originate as a local disease of some of the abdominal viscera; and in many of these cases, if the primary disease had been promptly recognized, and received its appropriate treatment, the fatal result might have been averted.

These errors in diagnosis arise from causes which are manifest. In the first place *a localized peritonitis has a tendency to become rapidly diffuse, and to hide the original trouble behind the extreme tenderness, the tympanitic distension, and the general violence of its symptoms.*

It is an easy matter to diagnose an uncomplicated disease where any single organ is affected. So in thoracic affections, where it is common to find uncomplicated diseases, we can, by auscultation and percussion, and by the general symptoms of the patient, locate the disease with positive certainty, trace its extent, and mark its progress with nearly as much precision as though it were a demonstration in mathematics. But in the abdominal cavity, unless the primary trouble is known before peritonitis occurs, it may become totally obscured by a diffuse peritoneal inflammation, so as to be beyond our power of detection. There are some diseases in which this obscuration is peculiarly apt to occur, and their relative frequency may be understood by consulting the following table,* which shows not only the large proportion of cases due to simple extension of the disease from the viscera to the serous membrane, but the forms of disease by which peritonitis is induced; 261 instances from 501 are thus referable to direct extension:

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* Habershon, Diseases of the Abdomen, third edition, p. 640.

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From hernia, of which 19 were cases of internal obstruction,	102
" injuries or operations, ...	35
" perforations of the stomach, ileum, cæcum, appendix, etc.,	43
" perforation leading to fecal abscess, ...	17
" typhoid ulceration without perforation, . . .	5
" disease or operations upon the bladder or pelvic viscera,	42
" disease of liver, gall-bladder, etc., ...	11
" acute disease of the colon, ...	3
" diseases of the cæcum or appendix, ...	3
	261

As an instance of the tendency of acute peritonitis to obscure the primary trouble the following case is a fair illustration:

CASE I. *Perityphlitic Abscess—Operation—Recovery.*—Mrs. M., thirty years old, was just recovering from diphtheria, and suffering from extreme mental and physical depression. Symptoms of malarial fever developed, and in about two weeks' time the general aspect of the case assumed a typhoid character. There was tenderness in the right iliac region; constipation; a heavily coated tongue; dusky, flushed face; dull, apathetic look; drowsiness, with a pulse of 100, and temperature of 104°. The tenderness increased, spread over the abdomen, and was associated with occasional attacks of colic. A cathartic acted well upon the bowels, and removed the tenderness in some degree; but the tympanitic distension remained, so that it was difficult to detect any local trouble. The condition of the patient growing worse, at the instance of her family physician, Dr. J. G. Baldwin, I examined the case. The patient was fat; the abdomen tympanitic, and the tenderness extreme; but, by careful manipulation, a deepseated tumor could be outlined in the right iliac fossa, distinctly circumscribed and non-fluctuating. It was diagnosed as a perityphlitic abscess, and an operation advised. The advice was taken, and the operation performed by using an aspirating needle as a guide to show the depth of the pus, which, in this instance, was two and a half inches below the surface; and, following the guide with a bistoury, opening the abscess freely, and giving exit to about a pint of fœtid pus. The recovery was slow, but perfect. The difficulty in this case was not entirely due to the presence of peritonitis, but was chiefly owing to the fact that the development of the abscess was insidious,

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without the rapid onset and marked characteristics that usually attend such cases; and this variation in the ordinary method of attack was, no doubt, produced by the debilitated condition in which the prior illness had left the patient.

Another case shows how easily one may be misled, even when the solution of the difficulty seems to be an easy matter.

CASE II. *Peritonitis from Internal Strangulation—Recovery.*—J. B., a colored waiter, aged 27, had carried an inguinal hernia of the right side for many years. Once or twice it had given rise to symptoms of strangulation, which had promptly subsided upon the reduction of the hernia by taxis. Latterly he had discarded his truss and had suffered no serious inconvenience, although the protrusion had increased in size. One day the old symptoms of strangulation appeared, and failing to reduce the hernia himself, he went from New York to his family physician in Albany, who endeavored to replace the hernia, as on former occasions, but found it impossible. An operation was advised, but the patient became alarmed, refused the operation, and came back to New York. All this time there were symptoms of acute strangulation, vomiting, constipation, abdominal distension, and tenderness, and it is remarkable that in such a condition he was able to travel. Four days afterwards I was called to see him, and found him vomiting incessantly and in enormous quantity, the ejected fluid being stercoraceous in color and odor. The abdomen was distended to its utmost limits, tight and resonant as a drum. There was tenderness, fever, intense thirst, and all the symptoms of an acute and diffuse peritonitis.

The case seemed to be clearly one of strangulated inguinal hernia, the history of the case and the presence of the hernia being sufficient evidence of the cause of the trouble. Herniotomy was advised and at once performed. Cutting down upon the sac I found the hernia irreducible, and opening the sac I found no strangulation whatever. Enlarging the wound and drawing down some 18 or 20 inches of the intestine, I found nothing but the evidence of peritonitis. Introducing my hand through the wound I endeavored to discover the location of the obstruction, but failed to detect it. On closing the wound I was confident that a post-mortem would reveal an obstruction of the

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small intestine. But the man recovered. The symptoms continued without material change for about two weeks longer; then came sudden relief of the obstruction, copious evacuations, and final recovery. In such a case it would seem as though a mistake was inevitable, unless the patient could have been examined at an earlier date, before the peritonitis had obscured the primary trouble.

II. Continuing the clininal examination of peritonitis in its relation to the diagnosis of associated diseases, we find that, while it may obscure primary diseases, as already described, it affords another opportunity for mistakes from an entirely different cause, and one of peculiar interest in surgical practice, viz.:

Dangerous and fatal conditions due to the effects of peritonitis may be concealed by the presence of other and less dangerous diseases. This comes from the well-known clinical fact that similar symptoms may arise from different pathological conditions. The following case, unique of its kind, impresses this lesson very forcibly.

CASE III. *Ovariotomy—Death from Strangulation of the Intestines by Pelvic Adhesions that were Inoperative so long as the Tumor remained in situ.*—In April, 1878, I removed an ovarian tumor from Miss B., aged 45. It had been growing for nearly two years. Her previous clinical history was one of constipated habit, with occasional attacks of what she termed "bilious colic." The colicky turns, however, had diminished in force and frequency from the time the ovarian tumor appeared. There was also a history of slight attacks of localized peritonitis in the right iliac region. At the time of the operation her condition was excellent, but there was one marked peculiarity that I had noticed, and from which I apprehended some difficulty during the operation, namely, the existence of distinct crepitation over the right iliac region. This crepitation could be heard whenever the patient took a deep inspiration, and was palpable to the hand when placed over the part. I inferred extensive and dense adhesions, chiefly parietal, anticipated considerable difficulty in removing the tumor, and stated my apprehensions to Drs. Helmuth, Butler, Beebe, and others who were present and kindly assisted in the operation.

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There proved to be no difficulty whatever in the operation, not an adhesion appeared, and the tumor was removed without delay or accident. It was an oligocyst, colloid mainly, of about 15 pounds weight. The operation had been performed with such facility that there seemed to be no necessity for any manipulation of the parts; a little superficial sponging and the insertion of a drainage-tube was the extent to which I considered it wise to disturb the contents of the abdomen before closing my incision.

She died on the eighth day, not from peritonitis nor septicæmia, but from what appeared to be an intestinal obstruction. The symptoms appeared very soon after the operation, and were so suggestive that I explored the wound to see if any loop of the intestine could have been compressed between the stitches. The behavior of the drainage-tube excited my curiosity, for a few hours after the operation I found that its internal extremity, inserted behind the uterus, had travelled over towards the right side. There was but slight fever or tympanitis until the last day, but in every other particular there seemed to be no characteristic feature that was wanting; death came apparently from exhaustion.

At the post-mortem examination it was found that the broad ligament on the right side was transformed into a dense fibrous band, half an inch thick, and its pelvic attachment was spread out in a mass of adhesions which inclosed part of the small intestine in their grasp, and the constriction thus produced had rendered the intestinal canal impervious. The uterus was drawn over to the right side by the contraction of this elastic band, of which the broad ligament was composed, and this explained the curious migration of the drainage-tube. The most peculiar feature of this condition is now to be noted. The ovarian tumor was also on the right side, and during its growth it had pushed the uterus over towards the left side, as far at least as the median line. The effect of this was to stretch the adhesions. Now upon taking hold of the uterus and making such traction as to bring it into the same relative position it had occupied when the tumor was present it was found that the tension upon the adhesions constricting the small intestine was so directed as to relieve the stenosis in a measure, and render the intestinal canal per-

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vious to fluids to such an extent as to preserve their functional activity. On letting go of the uterus the constriction became complete again, and the intestinal canal was impervious. Here then was a remarkable case in which, so long as the ovarian tumor remained *in situ*, the intestine was pervious, and the life of the patient depended on the tension produced by the tumor. In removing the tumor I took away the only chance for life, for as soon as the uterus was released from its position the tension was relieved, and the adhesions contracting upon the small intestine produced immediate strangulation.

One cannot see many cases of fatal intestinal obstruction without appreciating the importance of peritonitis as a remote cause of the trouble in forming adhesions and bands which at a later date may become the active agents in producing strangulation. Such cases are apt to mislead us by presenting an appearance of functional disorder; generally it comes as a case of habitual constipation with occasional turns of bilious colic, when, in reality, there is a mechanical constriction of the intestine that some day suddenly passes the bounds of functional tolerance and becomes a fatal case of obstruction.

III. The method of exploring the abdomen in cases where acute peritonitis exists as a complication is a very important matter. In this connection it is to be remembered that the tendency of modern pathological research is to deny the existence of idiopathic peritonitis and consider every case as dependent on some primary disease. Without discussing the question it is far safer to assume that this theory is correct, and to direct our examination towards the discovery of the primary cause of the peritonitis than to be content with the mere knowledge that peritonitis is present. By referring to the table already given it will be seen that the intestine in some portion of its extent contributes by far the most important list of primary causes for peritonitis. It will be seen that all of the two hundred and sixty-one cases came from direct extension of the inflammation to the peritoneum. The balance of the five hundred and one cases shows two hundred and forty which originated in the following manner:*

* Habershon, loc. cit.

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From Bright's disease,	63
" pyæmia (13), erysipelas (5), puerperal fever (10), pneumonia (3),	31
" tubercular disease,	70
" cancerous disease,	40
" hepatic disease,	27
" heart disease,	9
	240

We find then that clinically we may divide peritonitis into two great classes. In the first it occurs by direct extension; in the second it is connected with a changed condition of the blood, and is associated with and partakes of the nature of diseases that are mainly chronic in type and insidious in their development. The question will naturally arise, before exploring the abdomen, to which of these divisions does the case belong?

In surgery the first group is that which demands the closest scrutiny; in medicine the second group will afford a constant field for study. It is not proposed, however, to consider now the question of differential diagnosis, but merely the method of examining cases in which acute peritonitis is present, and where we wish to discover whether it coexists with some latent or primary disease. There are three impediments that prevent us from making a thorough exploration in cases of acute peritonitis:

First, the great pain and tenderness causes the patient to shrink from the slightest touch.

Secondly, the tympanitic distension of the abdomen and the spasmodic rigidity of the abdominal muscles obscures or prevents effective palpation.

Thirdly, there is a certain amount of risk attending the physical exploration of the abdomen in cases of acute peritonitis, since the amount of pressure and consequent disturbance of the inflamed parts, necessary to insure a thorough examination, may possibly increase the extent or intensity of the inflammation, besides subjecting the patient to the danger of shock.

We dispose of these three impediments at once by the employment of an anæsthetic, which abolishes the pain, diminishes the tonic rigidity of the abdomen and enables us to make an exami-

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nation so as to furnish the greatest amount of evidence with the slightest possible disturbance of the parts.

There are many cases complicated with acute peritonitis in which, with every known appliance at our disposal, an accurate diagnosis will be impossible. In a large proportion of such cases the determination of the precise locality or the exact nature of the primary trouble may be a matter of the greatest difficulty, but it is certain that we cannot pronounce any case to be either difficult or impossible to diagnose unless we have examined it in a condition of anæsthesia. There are, of course, many cases in which a resort to this expedient is unnecessary because the origin of the trouble is already sufficiently clear, as in cases of strangulated hernia, puerperal peritonitis, traumatisms, etc. But in those cases where the attack has been preceded by obscure symptoms of intestinal obstruction or visceral disease, and especially where, notwithstanding the spread of the inflammation, the point of its primary development remains the most tender and exhibits the signs of the highest relative degree of inflammation, under these circumstances we should not fail to make a thorough examination with the aid of an anæsthetic. The same rule applies if we find any portion of the lower abdomen abnormally dull on percussion, or if there is any swelling not tympanitic, and especially if the peritonitis began in the right iliac region and was preceded or accompanied by a tumefaction apart and distinct from the tympanitic distension. The effect of an anæsthetic in clearing doubtful cases is shown in the following example.

CASE IV. *A Tumor Diagnosed as a Fæcal Obstruction shown to be a Fibroid of the Uterus by the Aid of Chloroform.*—The patient, a lady of thirty-five, had been for years subject to habitual constipation, so that enemas or cathartics were a daily necessity. Her sallow complexion, headaches, furred tongue, and general malaise, furnished a typical example of what has been designated as "copræmia," from the septic effect of retained fæces. Gradually a tumor appeared in the region of the sigmoid flexure. Under the action of cathartics and enemas the tumor diminished considerably in size, but increased again when the bowels were neglected. On being called to the case I found what I supposed to be a fæcal accumulation in the sigmoid flexure of

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the colon. The tumor was about the size of the two fists, somewhat movable, and, on introducing my fingers into the rectum by conjoined manipulation, it was easy to determine the fæcal nature of the tumor from its doughy sensation, and from the fact that by moderate pressure the imprint of the fingers could be left on its surface.

And yet it was not a fæcal tumor. About a year afterwards I saw the patient again. She was suffering from a slight localized peritonitis; and, finding that the tumor was still in its place and increased in size, I administered Chloroform, and made a thorough examination. By perfectly relaxing the abdomen I was able to push aside some fæcal masses that had formerly lain between my fingers and the tumor, and thus demonstrate that the appearance of a fæcal tumor was due to a very simple cause. The tumor proved to be a fibroid, attached to the uterus by a pedicle.

The next case shows an opposite condition.

CASE V. *A Tumor Supposed to be a Pelvic or Uterine Fibroid Proved to be a Fœcal Impaction.*—This was an hospital patient, a woman of thirty-two, supposed to be pregnant, and sent to me for the removal of a large pelvic tumor that threatened to render natural delivery impossible. Upon admission there was considerable abdominal pain and tenderness. A vaginal exploration failed to reach the uterus, bnt revealed the presence of a distinct tumor, which could not be thoroughly examined on account of the extreme sensitiveness and inflamed condition of the parts. Chloroform was administered, and the diagnosis became clear at once. It was a fæcal impaction, and readily yielded to a full dose of Opium, followed by injections.

Similar cases might be cited to any extent to show that in the action of anæsthesia we possess the most efficient method of examining cases in which the existence of peritonitis, with its attendant pain, tenderness and tympanitic distension, render a thorough manipulation of the parts difficult and often impossible. With reference to the other means at our disposal for the examination of these cases, the use of the aspirator, percussion, palpation, auscultation, the significance of altered conditions in the quantity and constituents of the urine, etc., we need not devote

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any attention to them here, since they will receive ample consideration elsewhere.

IV. In the course of every disease in which peritonitis occurs as a complication there is, sooner or later, a condition of constipation that may be the first symptom to appear, and is certainly not the least in its significance. After important surgical operations, such as ovariotomy, and in fact in all abdominal surgery, the standard rule is to produce constipation by the administration of opiates or other agents. But if constipation occurs merely as a symptom of functional derangement, independent of any surgical operation, or if it happens in the course of any disease, the rule works the other way, and we are directed to relieve the constipation by cathartics. So settled have these opinions become that a word of explanation is necessary in advocating methods that are directly opposed to the accepted rules.

Constipation is not characteristic of abdominal inflammation only. The general process of inflammation, no matter where or what its origin may be, carries this symptom in its train at the early period of its history. Any surgical operation or injury attended by inflammation is followed by constipation as a general rule. It is true that there are certain antecedent disorders of the intestine of a chronic type, such as membranous enteritis, chronic dysentery, and chronic intestinal catarrh, that may still persist in the presence of an acute inflammation; but even these chronic discharges, in a large majority of the cases, follow the general rule. So after childbirth and after all capital operations we expect this symptom as a matter of course. Whether it be due primarily to inflammation or to surgical shock is immaterial, the clinical fact appears to include both causes. Hence, after ovariotomy it is unnecessary to confine the bowels by opiates, since there is generally no disposition of the bowels to move during the first week succeeding the operation. In my own experience in this operation I have had the best results in those cases in which I have meddled the least with functional conditions; and, in passing, the same remark applies to the use of the catheter. Cases occur in which we are obliged to interfere with the natural progress of an abnormal condition, but when such interference becomes a rule it is a bad one.

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In the absence of pathological facts we may assume that what is termed habitual constipation may be a purely functional derangement of some part of the digestive system occurring without inflammation. It is impossible to define with exactness the limits where constipation depending upon functional derangement ends, and constipation depending on some organic lesion begins, nor is it necessary for our purpose. When, however, to the constipation is superadded vomiting, colic, and fever, as repeated concomitants, we may safely assume that some organic intestinal lesion is present, no matter how long the habitual constipation may have existed. As a symptom it forms an important factor in the clinical history of all of the abdominal diseases in which surgical treatment is required, not merely as a concurrent symptom, but as one of the earliest premonitions of trouble, and it is sometimes a question of importance whether the use of cathartics is indicated.

In the premonitory stage of trouble, the period of incubation, when constipation is, perhaps, the most marked symptom, when all other signs are dull and obscure, and the disease has not become sufficiently pronounced for recognition, we may find the effect of a cathartic to be in every way beneficial. Again, when inflammatory action has just begun, and we are in doubt as to whether there is a mechanical obstruction of the bowels, as might occur in the differential diagnosis between perityphlitic abscess and intestinal obstruction, we may judge of the nature of the case somewhat by the action of a cathartic, and administer it for that purpose. There is another period, however, in which the constipation is most marked, and in which it is often a dangerous practice to use cathartics, for the safety of the patient may depend upon the inaction of the bowels.

A reference to the pathological condition will make this point clear. The fact that all the organs contained in the abdomen are enveloped, to a greater or less degree by the peritoneum, renders this membrane liable to the direct influence of contact with any inflammation that may occur on the surface of these viscera. The influence of mere contact with an inflamed surface is not recognized on the cutaneous surface of the body, except in diseases that are contagious by reason of some specific virus, or

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from the acrid nature of a discharge. The mucous membrane is unquestionably influenced by contact with an opposed surface of inflamed mucous membrane. But in the serous membranes of the joints, in the pleuræ, the pericardium, and the peritoneum, the inflammation is propagated directly by such contact. Hence it is rare to find marks of inflammation on one peritoneal surface, as of the intestine, for instance, without a corresponding mark upon the parietal peritoneum, or whatever part of the membrane was in contact with the inflamed portion. So between the convolutions of the intestines, between the upper surface of the liver and the parietal membrane, between the ascending colon and the liver, and between the uterus and rectum, we find frequent examples of the propagation of inflammation by contact, and this is all the more obvious because the inflammatory action is rarely observed spreading with uniform progress by continuity. It jumps from one location to another, and while it may in the end involve the whole membrane, its method of progress is peculiar to the tissue involved.

The result of this inflammatory process is an exudation which varies in character according to the intensity of the inflammation. In acute, sthenic, cases it is solid lymph, covering the whole inflamed surface of the peritoneum. In asthenic cases it is purulent for the most part, a few flakes of lymph being found here and there, but the largest part of the effusion gravitates towards the pelvis, where it is found as a milky fluid. The first effect of the exudation is to infiltrate and soften the tissues from which it comes. Next we have an adhesion of the inflamed surfaces in contact with each other through the organization of the lymph exuded from them.

Here then we have two important pathological associations, namely, the softening of the tissues and the formation of adhesions. This may be a conservative process, or it may precipitate a fatal result, as will appear from a brief consideration. Exudation may be part of an ulcerative process, or part of a reparative process; in fact, both actions may go on at the same time,—ulceration of the mucous membrane of the intestine, and the deposition of plastic layers on its peritoneal surface, uniting it to the parietal membrane or whatever portion of the peritoneum happens to be adjacent. Now the danger in this condition does

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not seem to lie so much in the tendency of the destructive process to outrun the reparative action, as in the fact that the tissues are softened by the process of exudation so as to be easily torn. If the lymph of the intestinal peritoneum was like a piece of court-plaster, covering a weak point and adhering to that alone, the process would be simple and effective. But it is unfortunately adherent to everything else as firmly as to the original seat of inflammation, as though the court-plaster was adhesive on both sides alike. This comes from the fact already stated, that serous inflammations are propagated by contact. We can thus appreciate the danger that will threaten the integrity of the part, for if too much tension is brought to bear upon the inflamed tissues after the adhesions have attained any firmness, the weakest part must give way. Hence the sudden and fatal collapse that sometimes occurs in peritonitis associated with enteritis, even when the patient has apparently passed the most dangerous period of the disease and is rapidly convalescing. We may naturally infer, then, that the action of cathartics may be to produce a fatal tension on the softened tissues, and that the proper time for their use is either before exudation occurs or after the adhesions have become firm enough to bear any strain upon them. We cannot always determine this period, but we may at least, in cases of doubt, refrain from a method of treatment that is not often necessary.

V. The influence of peritonitis upon the result of surgical operations upon the abdomen must enter largely into the question of prognosis. Its action in this respect is not always capable of explanation, nor can we draw conclusions from statistics that will enable us to formulate any rules that should be considered of much value in any single case. Nevertheless clinical experience in this matter is so great that we may readily apply its lessons in practice without questioning the frequent exceptions that may occur in the individual experience of others.

It is a fact of much importance that the peritoneum may, under some circumstances, lose its extreme delicacy in texture, and become so altered as to exhibit but little tendency to inflammation after an abdominal section. Such cases are oftenest met with in old hernias and in cases of ovariotomy, when a tumor of consid-

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erable size has existed for two years or more, and where there have been repeated attacks of subacute peritonitis. Under these circumstances the peritoneum may become thickened and toughened, as it were, so that it loses some of its anatomical and pathological characters as a serous membrane. We may regard this condition as probably due in most cases to the mechanical action of the tumor, for it only occurs in tumors large enough to exercise pressure and friction upon the parietal peritoneum, and it is particularly the peritoneal lining of the anterior abdominal wall, where pressure and friction are greatest, that exhibits this condition in the most marked degree. Where this condition exists there is less liability to acute peritonitis, and hence we may draw a practical inference from this behavior of the peritoneum, viz., that small tumors are more dangerous to operate upon, so far as peritonitis is concerned, than those of larger growth. In looking over Spencer Wells's table of 500 cases of completed ovariotomy I find the following statistics upon this point: There were 128 fatal cases in all. In 68, the tumor weighed over 20 pounds,—22 deaths from peritonitis. In 45, tumor weighing 20 pounds and less,—20 deaths from peritonitis. In 15, no weight being given,—7 deaths from peritonitis. It seems then that, in the case of tumors weighing 20 pounds and less, nearly half the deaths were from peritonitis, while with the larger tumors the deaths from peritonitis were not quite one-third. The following case illustrates the fact that various operative measures, such as tapping, electrolysis, etc., may induce a subacute peritonitis, which leaves the serous membrane thickened and but little susceptible to inflammatory action.

Case V. *Ovariotomy after Electrolysis—Recovery.*—In July, 1875, I performed ovariotomy on Miss B., of Leeds, N. Y., being kindly assisted by Drs. Philip, Dean, Mackey, and Jewell, of Catskill. The tumor was a proliferous cyst of about 30 pounds, was removed without difficulty, and the pedicle was brought outside, being secured by acupressure needles with an elastic ligature beneath them. She made an excellent recovery, suffering more from prolonged vomiting, due to the Chloroform, than from anything else, and only manifesting very slight symptoms, if any, of peritonitis. The interest of the case is connected with the

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condition of the peritoneum. The incision was five inches long, and on coming down to the peritoneum I found a tissue so thick that at first it seemed to me that I must have already divided the peritoneum unawares and reached the cyst itself. A careful examination, however, showed that the structure was the peritoneum itself, enormously thickened and highly organized, but not inflamed. On cutting through this membrane, which appeared to be about a quarter of an inch thick, the glistening wall of the cyst was brought into view. There were numerous adhesions between the cyst and the peritoneum in the neighborhood of the incision, but they gave no particular trouble. This peculiar condition of the peritoneum was not diffused, it only existed on the anterior parietal wall over a surface of about six inches square, and the incision traversed its centre. Now this locality had been the field of some peculiar treatment to which the patient had been previously subjected, and, as it seems to indicate the origin of the inflammatory action which resulted in this peculiar hypertrophy of the peritoneum, it is worth noting.

About six months before, the patient came to me for treatment and, having had some excellent results from electrolysis in cases of hydrocele, I determined to try the method on an ovarian tumor. With her consent I performed electrolysis with a freshly charged Stöhrer's zinc-carbon battery of 32 cells, using the full power of the battery for twenty-five minutes, with three needles from the negative pole inserted deeply into the tumor, and the positive (sponge) applied to the outside of the abdomen. During this process the patient was, of course, under an anæsthetic. The positive sponge was moved over the abdominal surface so that it travelled over the part corresponding to the portion of the peritoneum that was afterwards found to be hypertrophied. A very remarkable result of this operation was evident to all who were present, viz., before the needles were withdrawn the tumor had sensibly decreased in size until at the end of the operation it was at least one-third smaller than before the operation. A slight attack of peritonitis followed the operation, but there was no permanent improvement, for in two weeks' time the tumor was as large as ever. I then aspirated the fluid and sent her home. Three months afterwards she returned with the tumor refilled,

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and the electrolysis was repeated in the same manner as at first. This time, however, there was no diminuition in the size of the tumor during the operation, on the contrary there was an increase in size if indeed any change occurred. A slight peritonitis followed as before, and she was again tapped and sent home. Three months after this I removed the tumor as already described.

Another feature of peritonitis, and one more generally appreciated than the preceding condition, is its tendency to assume the sthenic form in those who in vigorous health are compelled to undergo a surgical operation involving the peritoneum. Hence we meet with the most rapid deaths in those whose previous health and strength count for nothing against an attack of peritonitis and, *per contra*, the most remarkable recoveries occur in those whose debility would seem to be somewhat of a safeguard against the violence of peritonitis, on the principle that little fuel makes but a small fire. This experience is not invariable, however, nor is it peculiar to peritonitis alone, since we find the same characteristic applies to some extent in all inflammations.

Again we find that peritonitis in some conditions, such as strangulated hernia, perinephritic abscess, etc., has but little tendency to become diffuse provided the operation is performed in time. In the case of hernia, when the incision implicates the peritoneum, the resulting inflammation remains in most cases entirely local, the exceptions generally occur in recent and very small protrusions; the rule applies oftenest to those that exhibit the condition of hypertrophy already mentioned.

In cases of intussusception we must note a peculiar feature in the absence of peritonitis, at least in the beginning of the trouble, and many marked and even fatal cases of intussusception may run their course without any pronounced symptoms of peritonitis. In the rarer operations of splenotomy, hysterotomy, etc., while the dangers from peritonitis are not lessened there is an increased mortality from hæmorrhage and surgical shock.

In all diseases of the abdominal viscera acute peritonitis may occur not only as an intercurrent trouble, but may also exist at the time when we are called upon to decide upon the question

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of operation, and hence we may have to consider the propriety of operating upon the abdomen in the presence of an acute peritonitis.

In the case of ovarian tumors that have finally ruptured and poured their contents into the peritoneal cavity exciting a peritonitis that must prove fatal unless the irritation is removed, experience has proved that such a condition demands an immediate resort to an operation as the only chance of saving the patient. The indication is imperative, and the existence of peritonitis cannot be admitted to be a contraindication. And so in strangulated hernia, in perityphlitic abscess, and in intestinal obstructions, where, if we wait for peritonitis to subside, we may practically wait for the patient to die, we are to bear in mind that the primary trouble upon which the peritonitis depends must be removed before we can expect a subsidence of the peritoneal trouble, and under such conditions there is no choice but to operate. Thus the existence of peritonitis may, in some cases, prove to be an indication for an operation instead of an argument against it.

There is another class of cases, however, of a more chronic type, in which peritonitis may occur as an occasional concomitant, and in which we may expect it to subside, leaving the primary disease alone to be dealt with. In such cases it would of course be unwise to select a period, when the peritoneum is already inflamed, as the proper time to expose it to a traumatism. And yet no special rules can be given to guide us in such cases, for the question of operation must finally be determined in accordance with the individual experience of the operator, whose decision must include the contrasted dangers of haste and delay.

Just here we are brought face to face with the great responsibilities that must be accepted by the surgeon who operates in cases requiring abdominal section, for, in the present state of surgical and pathological science, the responsiblity must be to a great extent an individual or personal one. Our opinions of the nature and progress of many of the diseases of the abdominal organs are very different from those which prevailed half a century ago, and hence we cannot be expected to follow the same

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method of treatment to-day that was then in accordance with the most approved rules of surgical science. Ovariotomists have led the way into a field that was forbidden ground, and have demonstrated that the cavity of the abdomen is a proper and legitimate field for operative surgery. The success of ovariotomy has led to the performance of still more radical and hazardous operations, so that we may rationally consider the propriety of extirpations of the uterus, the spleen, the kidney, and large portions of the intestinal tube, in the light of what has already been accomplished successfully in this department of surgery. Nevertheless we must consider that, so far as absolute decision upon many of these topics is concerned, we are in a transition stage of surgical experience with larger possibilities developing before us, but with increased responsibilities that must be assumed if we would enter this field. And since under these circumstances personal experience is of more value than personal opinion, clinical facts outweighing theories, we must study attentively the various operative measures that have proved to be most successful in overcoming the difficulties and dangers that attend the surgical treatment of diseases of the abdominal viscera.

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HERNIA.

By J. H. McClelland, M.D., Pittsburg, Pa.

The term hernia in its broadest application, relates to any abnormal protrusion from any cavity of the body, whether through an opening natural or acquired.

In a more restricted sense it refers to protrusions from the abdominal cavity, through openings from which also escape the larger arteries.

This paper proposes to treat of certain abdominal herniæ, not however with reference to their radical cure, which has been assigned to my colleague, Dr. Thomas.

For the general description and pathology of hernia, all have access to the textbooks (nothing better than Agnew's classical work just issued), and I have no desire to unnecessarily occupy the time of the Institute.

Attention is invited, *first*, to the reduction of hernia, and *second*, to the means of retention.

Reference is made in this connection to *reducible* hernia, and, fortunately, the majority of cases are reducible. In no case should a hernia remain unreduced a single moment if it can be avoided. It is like the sword of Damocles.

As a rule, the smaller the protrusion, the greater the danger; or, perhaps, it would be more accurate to say, the smaller the aperture, the greater the danger. That cases have remained unreduced for weeks, months, or years, is true, but heedlessness in this respect amounts to fatal neglect sufficiently often to serve as a warning.

The manipulatory effort by which reduction is secured is known as *taxis*, and this is entirely sufficient in most cases.

Taxis is practiced with the patient in the recumbent position,

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hips elevated and legs flexed. *These conditions are important,* yet I have known one case in which the patient always succeeded best in reducing the hernia when on her feet, drawing up the contents of the abdomen with the diaphragm, assisted by her hands across the lower part of the bowels.

It is scarcely necessary to dilate upon the necessity for careful, gentle, persistent taxitory effort, before resorting to cutting. Success may follow after three or four hours, applying hot arnicated lotion for half of each hour. Nux vomica, Opium, or some other indicated remedy should be exhibited. After a reasonable trial (say an hour) the patient should be put under an anæsthetic and renewed effort made.

It not infrequently occurs, owing to the delay or the heroic efforts of the attendant or patient himself, the surgeon finds an *inflamed hernia.* He must now decide whether it is best to proceed at once or adopt measures to reduce the inflammation.

Good practice will probably suggest the following: After making some gentle manipulation to assure himself that the hernia is not readily reducible, he should apply hot arnicated fomentations and internally give Belladonna, unless some other remedy is specifically called for by the symptoms. Provided, always, urgent symptoms do not call for immediate relief. In this case, without further delay, an anæsthetic should be administered, a final effort made, and if this prove futile, *herniotomy.*

It, however, frequently transpires that a few hours of quiet rest under the influence of the remedies above indicated, is followed by the reduction of the hernia, without difficulty.

The obstructed intestine may gradually become distended by fecal matters, so as to be, for the time at least, irreducible; or a portion of the omentum may become swollen by impeded return circulation and be in the same plight. It is thus imprisoned, *incarcerated,* but not necessarily strangulated. We have symptoms of distress, nausea, and pain, and the condition is one calling for prompt, though not necessarily immediate relief. Under full anæsthesia, careful persistent endeavor is now made to return the bowel, without too soon becoming discouraged, for much may still be done by fomentation and the administration of the internal rem-

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edy: Perhaps, Opium, Plumbum, Nux vomica, Veratrum, or Belladonna.

I have many times practiced with success a method which is also employed and described by Mr. Smyly, of Meath Hospital, England. This consists in passing the forefinger under the hernial mass, entering the canal as far as possible, and engaging the constricting ring so as to stretch the aperture and afford more room for the return of the hernia. No injurious pressure is sustained by this method, as the point of the finger hooks into the ring underneath the protruding viscus. I was recently successful by this method in a case after four of my old-school colleagues had failed and had decided upon cutting.

Holmes calls attention to the impunity with which the intestines may be punctured, and the success which may, in a given case, attend the withdrawal of gases and fluids from the imprisoned gut. With the aspirator this is indeed a harmless procedure and should not be overlooked.

I would lay special stress upon the importance of making sustained but gentle pressure upon the hernial mass with one hand, while with the other endeavor is being made at the constriction to effect the return of the bowel, or omentum, as we might say, piecemeal.

The efforts at reduction may, in most cases, be safely continued for three or four hours, but I trust this will not be construed into a recommendation to "pound and maul" at the offending gut for this length of time. If after reasonable time and effort the hernia remains unreduced, or symptoms of *strangulation* supervene, no time is to be lost. The appearance of symptoms of collapse or fecal vomiting contraindicate a moment's delay. Herniotomy is to be made in the usual way. Attention is called to the value of Levis's hernia director in this connection.

Effort should always be made when herniotomy is performed to secure the closure of the canal; and while it is not my province to discuss radical cure in this paper, attention is called to the use of catgut ligatures for this purpose. It is now two or three years since I first used catgut ligatures in the radical cure of hernia, first dividing the integument and superficial fascia, then introducing several interrupted sutures, by which the canal is

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closed. Previous to this I had used the catgut in the radical cure of varicocele, cutting down to the enlarged veins under Carbolic acid spray, ligating them and closing up the wound.

Means for the Retention of Hernia.—Straps and compresses of various kinds have been employed and may still be required at times for the retention of herniæ. Some form of truss is, however, to be preferred.

There are several points to be observed. The skin is liable to be inflamed or chafed, especially in children, when a truss is first worn. A lotion of alcohol or whiskey, to which has been added some pulverized alum (about a drachm to half a pint), will so harden the skin as to prevent trouble. The parts may be rubbed briskly two or three times a day with this solution.

The hernia should always be completely reduced (when reducible) before the truss is applied, and the patient should not rise from the bed until it is perfectly adjusted. This implies also that the patient should not remove the truss until after he has gone to bed.

If the hernia should wholly or partly protrude beneath the pad, the truss should at once be removed and reduction effected. The recurrence of this difficulty proves the inefficiency of the truss.

The selection of the truss is all-important. Trusses of hard rubber, celluloid, or leather covered, may be had of every shape. Penfield's, French, Marsh's and Sheldon's are good varieties. Thousands of trusses have been devised, each claimed to be superior to its predecessor. Some of them "fearfully and wonderfully made." The principle involved is simple, *i. e., well-directed retentive pressure.* To accomplish this are required a pad, a spring, a strap.

The pad may be hard rubber, ivory, hard wood, or softer material covered with leather. In every instance the form of pad is to be adapted to the case in hand, and in order to do this Dr. Knight suggests the use of soft wood pads that may be whittled into the very shape required, removable covers of soft leather being then added. The idea is certainly a good one.

The pad should be adjustable, so that its relations to the her-

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nial aperture and the spring will be such as to secure the aforesaid "well-directed retentive pressure."

The spring should be covered with hard rubber, celluloid, or leather, and just strong enough to retain comfortably the hernia. A powerful spring is sometimes employed to excite adhesive inflammation, but its continued use is destructive, inducing absorption of the tissues, and is not to be advised in ordinary cases.

The spring in inguinal hernia especially, should cross over the sound to the affected side, and even in double hernia a single spring will answer, the pads being attached by adjustable bars.

As a rule congenital herniæ, and even those of early childhood, are curable with a truss; in herniæ of adults the reverse is true. Mr. Nubert, of this city (Pittsburg), has devised a truss for inguinal and femoral herniæ which possesses excellent retaining qualities. It is simple in construction, the pads of a variety of shapes and sizes, the connecting bar adjustable, and made of malleable iron so that the pad may be made to assume exactly the right position.

Umbilical and ventral herniæ require a variety of means of retention. In small herniæ a coin fastened with adhesive straps is sufficient.

The large saucer-shaped pad of wood, with steel springs, has failed to give satisfaction in my experience; a pad fastened in a broad belt of stout webbing has done better. In some cases, which attain enormous bulk, nothing but a large abdominal supporter of leather or heavy webbing is of any service. Cases have occurred in my practice which have attained the dimensions of a large wooden pail, of course utterly irreducible.

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THE RADICAL CURE OF HERNIA.

By Charles M. Thomas, M.D., Philadelphia, Pa.

In practically considering the question of operation for radical cure of hernia, it might be well to bear in mind that in all cases, most or all of the following conditions will be found to be present:

1. A weakness and enlargement of the so-called rings or canals through which the rupture passes.

In inguinal and umbilical hernia especially, this enlargement is at times very great, even sufficient to allow the introduction of several fingers. It must be remembered, however, that this is not a real opening or breach from a mechanical lesion, but a simple stretching or protrusion of a naturally weak spot in the abdominal walls, and is often found as a congenital defect.

2. The formation of a covering or sac for the protruded viscera out of a stretched and displaced portion of the parietal peritoneum.

It is now conceded by most modern surgeons, that a hernia is very rarely caused by a sudden or violent straining or pressing of the abdominal contents through a simply weakened ring. On the contrary, it is more than probable that the defect is either congenital or of comparatively slow formation through a gradual local relaxation of the abdominal walls, and a correspondingly gradual stretching and pocketing of the peritoneum through the abdominal openings to form the hernial sac; the giving way of the rings being but a late manifestation of the lesion. Patients who suppose they have suddenly been ruptured are really deceived; the rupture with its peritoneal covering has been forming for some time before, and only becomes apparent externally at the moment of some unusual exertion of the abdominal compressors, which forces the mass farther outward.

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3. An abnormal lengthening and, at times, hypertrophy of the protruded viscera, and an elongation of their mesenteric attachment or support, by which a constant tendency to recurrence of the protrusion is favored, even after the most careful reposition.

4. In large herniæ, which have for a long time remained unreduced, such a lessening in the capacity of the abdominal cavity that the herniated portions can with difficulty be accommodated.

This condition I found very pronounced in operating on a large scrotal hernia which had been unreduced for many months; and a second time in a case of large congenital umbilical hernia, the child being but a few days old. Here, after having divided the strangulating bands, although there was no obstacle at the opening to the return of the intestine, the greatest difficulty was experienced in finding room for it within the abdomen.

With these facts before us, it would seem that an open or weak ring, plays by no means, the most important part in the formation and continuance of a rupture. If, therefore, it be admitted that a rupture depends for a cause upon something more than a sudden forcing of viscera through a weakened portion of the abdominal walls, it is fair to conclude that, in order to accomplish a thoroughly permanent cure, it must be necessary to remedy all of these organic changes just mentioned, and yet since with our present knowledge we are able to cope with none but the first (enlarged rings, etc.), it remains a question whether the operations commonly known as radical, really deserve the name, inasmuch as they neither affect the tendency to sac formation nor shorten the lengthened mesentery, etc., and only aim at overcoming the lesser—perhaps secondary—causes of the ruptures, viz., the enlarged abdominal canals or rings through the building up of mechanical external barriers of greater or less strength at these points. Under such circumstances it can hardly be a matter of much surprise that these operations have not met with more success.

In spite, however, of the almost insurmountable difficulties in the way of obtaining a really radical cure, cases will constantly arise in which an operation for the closure or narrowing of the hernial openings may be called for, and the only question then

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is, to what length we may go in our admission of cases to this class. At the present time most surgeons agree that a radical operation can only be recommended when the rupture is very annoying, and either not reducible, or, if reducible, cannot be held by a truss; or finally, when the hernia, in spite of every care, tends to increase rapidly in size.

It is for the future to decide whether these indications may or may not be increased through the employment of more effective methods than we now possess.

The various ways in which cures have been attempted may be considered as follows:

Posture—Natural Cures.—A very necessary factor in any radical cure is, that the abdominal contents shall not at any time enter the canals, and so long as the horizontal position and quiet is preserved, there is but little liability of this occurring.

Cases have been reported where patients, obliged on account of other illness to lie quiet for a long period have, upon their recovery, found their ruptures entirely cured.

Pressure.—In young people, and when the hernial passages are not large, a cure can occasionally be accomplished through the application of carefully adjusted pressure over the ring and sac by means of the hernia truss. The action of the truss upon the ring, is not to bring its edges together, but simply to prevent any prolapse of the viscera, for if the protrusion is but once allowed to occur, the treatment is entirely thwarted, and must be again started from the very beginning. Hence the necessity, where a radical cure is expected, of insisting upon the wearing of the truss both by night and day.

The further action of the truss is upon the sac, particularly at its neck, where, by the constant and firm pressure of its serous surfaces against each other, an adhesive inflammation is finally set up sufficient to cause closure of its cavity.

In order that the pressure be effective, it is of course necessary that the truss pad be made of some hard though polished material, such as wood, ivory, or hard rubber, and that it be sufficiently large to overlap the edges of the hernial ring, for if it is smaller, the integuments will be pushed into the open ring, and, acting

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as a wedge, will tend rather to enlarge than contract the opening.

With children under ten years, in whom the prospects of cure are far surer than at any other age, the truss should be worn for at least two years uninterruptedly, and for a third year leaving it off only at night or when lying. In adults a cure will sometimes take place in this way, but only when the truss is worn continuously for many years, and when the rupture has been small. After the removal of the truss, when a cure has apparently taken place, the greatest precaution should be taken against abdominal straining or sudden exertions.

Operations.—The object of all the more purely operative methods has been in a general way to obliterate by inflammatory action the hernial passages from the rings outward. Some, particularly the earlier operations, were directed mainly toward the obliteration of the hernial sac and the closure of its neck, while in the more modern procedures, the aim has been to include the hernial ring in the operation.

The earliest accounts of the radical operation for hernia are found in the writings of Celsus, who advised that the tissues overlying the hernia be carefully cut through until the hernial sac was exposed, when, the ring being enlarged, the viscera were replaced and the wound allowed to heal by granulation. This would seem to have been simply our present operation for strangulation without opening the sac, as no mention is made of any interference with this, his object evidently being to produce a dense cicatrix, which was to act as a barrier to the recurrence of the prolapse. In others of his writings, however, he mentions the cutting into and removal of a portion of the sac, and at times overlying integuments, for the purpose of producing a cicatricial shortening of the soft parts.

Heliodorus, in the time of Trajan, advised and practiced the extirpation of the sac at as high a point as possible.

Leonides, of Alexandria, in the beginning of the third century, believed that the formation of a tough scar through the application of the hot iron was the most favorable operation.

In the early part of the seventh century, Paul of Ægina, after laying bare the sac of a scrotal hernia, transfixed it near the neck

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with a double ligature and tied it tightly in halves. The sac below the ligature was then cut through and removed, *together with the testicle.* In other cases the sac was invaginated by means of a probe, and stitched fast inside the inguinal ring, there to act as a sort of plug. This idea was again revived in the operations of Gerdy, Würtzer, and others in more recent times.

Following the teachings of Paul of Ægina, the method of castration was practiced by numbers of irresponsible travelling operators (so-called rupture cutters) from those early times, up to within less than a hundred years ago, and singular as it may seem, not only did large numbers of the victims survive this barbarous operation, but many were permanently cured.

In one diocese in Germany there were found five hundred children and two hundred adults castrated.

In the early part of the eighteenth century, Freytag, of Zürich, dissected down upon the sac, returned its contents, and tied the neck as high as possible. The ligature ends were brought out through the wound, and left till they came away by suppuration. Although this operation was said to be quite successful, and was practiced by a number of surgeons of that time, it soon fell into disuse, and was for some time replaced by crude endeavors to block the passages with an eschar formed by caustics or the hot iron.

Petit condemned such operations, and advised that the sac, after having been freed of all adhesions, should be pushed through the hernial ring, as high in the abdomen as possible, the wound being left to heal by granulation. As, however, his results were not satisfactory, he finally discouraged even this, and advised his patients to be satisfied with a well-fitted truss.

Ligation of the neck of the sac, as practiced at intervals from the seventh to the fifteenth century, was really tantamount to the castration operation of Paul of Ægina, inasmuch as the spermatic cord was included by the ligature. It was not until the sixteenth century that Ambrose Paré performed ligation without injury to the cord. Rousset, Petit, Abernethy, Langenbeck, and others, followed him in practicing the same operation until the early part of this century. The plan consisted in thoroughly freeing the neck of the sac, and after the reposition of its con-

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tents, tightly ligating it as high as possible. The sac below the ligature was then cut through, and the ligated stump replaced within the canal.

About this same period Le Blanc, Sharp, and others, laid open the parts and stitched together the edges of the ring or canal, leaving the sutures till suppuration had set in. This operation has been in late years repeated, with slight modifications, in this country, by James Wood and S. D. Gross, with tolerable success.

For more than a century past, attempts have been made by various operators, to obliterate the hernial sac by cutting into it, and introducing foreign bodies for the purpose of exciting profuse suppurative inflammation, but they have been found very unsatisfactory.

Thus Bonnet, in the early part of this century, passed needles through the sac in such a manner, that by means of corks, with which they were provided, a constantly increasing pressure could be made upon its walls. Later Belmas introduced pieces of dried gelatin, with a needle constructed for the purpose, and left them there, in the hope of causing sufficient inflammatory action to close the sac.

Maesner passed threads through the neck of the sac and allowed them to remain for two or three weeks, and although he claimed this to be a radical operation, he nevertheless did not allow the patients so operated on to go about without a truss. The unusual number of fatal cases following this method, soon brought it into disrepute.

Up to the present century, most of the operations, as has been shown, consisted in laying bare the sac by a dissection ; but since that time the subcutaneous methods have taken the preference, and instead of exciting suppurative action in the tissues, the setting up of a simple adhesive inflammation was attempted.

Velpeau was the first to employ subcutaneous injection of irritants into the sac, the idea suggesting itself to him from the success he had obtained by this means in the radical cure of hydrocele. The operation was done with a small trocar and canula, the latter having openings in the side.

Guerin and others sought a similar result in subcutaneous

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scarification of the sac, and although the risks were slight, but few cases of cure were reported.

The recurrence of the hernia after this and similar operations was so constant as to oblige surgeons to turn their attention to other methods offering surer results. As experience had already taught that the organic plugging of the canal with the inverted hernial sac, as practiced by Petit and others, was not only ineffectual, but, as it required the dissection of the overlying parts, was a more or less dangerous operation, the idea of invaginating all the soft parts for the plug, was suggested by Gerdy, and in 1835 carried into effect by him. He describes the operation about as follows, it being of course applicable to inguinal hernia only. The viscera being carefully replaced, the scrotal tissues are caught upon the point of the index finger of the left hand and pushed as high as possible through the inguinal ring; then a threaded fixed needle, with an eye in the point, is slipped along the finger until the point reaches the top of the invaginated tissues, when it is thrust through all the overlying parts and made to appear on the abdominal surface, and one end of the ligature is drawn out. The needle, without unthreading, is then drawn back till the point is again on the scrotal side, when, at a short distance from the first puncture, it is a second time thrust through to the abdominal surface. The other ligature end is then unthreaded and the needle withdrawn entirely. The ends of the loop so formed are then tightly fastened, while the inverted scrotum is thoroughly pushed up with the finger or a sound. A caustic application is now applied to the contiguous inverted scrotal integument, the object being to cause union of the raw surfaces, and so secure for the inguinal canal a firm organic plug.

The original method of Gerdy has since been much modified, both by himself and others, but the principle of invagination remains the same in all. In 1838 Würtzer, of Bonn, Germany, considering that the simple adhesion of the invaginated scrotum to the neck of the sac was insufficient to hold the scrotum in place, endeavored to accomplish a complete obliteration of the invaginated anterior wall of the sac. For this purpose he had constructed a so-called *invaginatorium*, consisting of two plates, one of which being passed into the inguinal canal, instead of the

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finger, is held in place by a long needle passed through it and the abdominal walls into the second plate, which is made so to articulate with the first that it lies immediately over it upon the abdomen, and by means of a screw the soft parts held between the plates are gently compressed until the included sac-wall is obliterated.

Max Langenbeck and Valette went still farther than Würtzer, and by means of a greater pressure of modified plates and the use of active caustics, produced an actual gangrene of the parts lying between them.

Other operations of a similar character have, from time to time, been introduced, as, for instance, that of Wood, of London, and Agnew, of Philadelphia; but they are all only greater or less modifications of Gerdy's method, and have been attended by but little, if any better result. We have no knowledge of the number of cases cured by Gerdy, but it is well known that there were four fatal cases out of sixty-two treated by him; a mortality sufficient to cast it out from a place among recognized surgical procedures.

Owing to the discouraging results of these late attempts, the radical operation for a number of years fell into marked disfavor with the majority of surgeons, and no new method was offered to the profession until 1876, when Dr. Dowel, of Texas, brought forward his plan of circumclusion of the boundaries of the inguinal canal. After making sure that the hernia has been entirely reduced, he passes the index finger into the inguinal canal, carrying ahead of it the tissues of the scrotum. The only instrument used is a semicircular needle, about three inches long, sharpened and eyed at either end, and carrying a heavy silk thread. This needle is entered about an inch and a half above the external ring, and passed *behind* the invaginating index finger across the canal, and brought out on the opposite side, near Poupart's ligament. Before the second point of the needle has left the tissues, it is again made to cross the canal backwards as it were, but this time in front of the finger, and reappears at the first opening or point of entrance. The needle is then unthreaded and withdrawn, leaving the ligature loop entirely encircling the canal, and the cord hanging from a common opening. A silver wire is now fastened to the silk thread, and as the latter is with-

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drawn the wire naturally follows and takes its place. After a number of such stitches have been introduced, they are each firmly tightened over a compress of lint. They are all removed on the eighth day, and the patient allowed to go about on the twelfth. Dr. Dowel reports a large per cent. of cures in this way, but a longer period of observation will be required before a correct judgment can be formed as to the value of this method.

From the time of Velpeau to the present decade, the method by subcutaneous injection of an irritant or astringent fluid had been entirely without advocates, but a few years since, Schwalbe, of Germany, and Heaton, of Boston, revived the practice.

The former injected into the ring and tissues about it, a small quantity of alcohol, at intervals of five to nine days, and claimed for the limited number of cases treated a uniformly good result.

The *Heatonian method* consists in the hypodermic application to the ring and contiguous tissues, of a few drops of the fluid extract of *Quercus alba*, or white-oak bark. The operation was given to the profession by Dr. Warren, who was an assistant of Dr. Heaton. The latter, it is said, practiced this operation for a long time as a secret method.

The instrument used by Dr. Heaton is the ordinary hypodermic syringe, the needle of which is provided with orifices on the sides, for the purpose of making a lateral distribution of the liquid.

The instrument has been variously modified by Drs. Warren, of Boston, Janney, of Philadelphia, and Dr. Garmo, of New York.

In performing the operation, the hernia must first be entirely reduced. A finger being then introduced into the inguinal ring, to act as a guide to the point of the syringe needle, the latter is thrust into the abdominal walls until it lies in close relationship to the ring and canal, when by slowly screwing the piston home, about 10 minims of the extract is deposited in the tissues. A firm compress is now carefully bound over the parts, and the patient put to bed for a fortnight.

Those who have practiced this procedure claim very good success from it.

The injection fluid is prepared as follows: Evaporate the fluid

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extract of white-oak bark to the consistency of glycerin. To this add an equal quantity of absolute alcohol, and to a half ounce of this mixture, add a half drachm of Sulphuric ether and two grains of Morphia sulphate.

A new epoch appears to have been opened for the radical cure of hernia, by the general introduction of Lister's *antiseptic treatment,* especially in England and Germany. The brilliant results attending its application to almost every department of surgery, has induced operators, particularly in the above-mentioned countries, to attempt to utilize it for the purpose of more safely reintroducing the old operation of Celsus and Heliodorus, which had been discarded more on account of the danger attending them, than because of doubt as to the correctness of the principles underlying them.

To Steele, of England, belongs the credit of having first applied the Lister method to this operation. In an article, published in 1874, in the *British Medical Journal,* he gives the details of an operation upon an eight-year-old boy, with a large congenital inguinal rupture, in which he freshened the columns of the ring, and drew them together with two catgut sutures without disturbing the sac. Recurrence took place six months after, when the operation was repeated. A year later there was no sign of return; the patient had, however, worn a truss since the last operation.

Since Steele's case, most of the reports of the Lister method have been from Germany. The operation has generally consisted in cutting down upon the sac, and where it can be emptied with certainty, it is ligated tightly at the neck with the catgut ligature or carbolized silk. The edges of the ring are then brought together with continuous or interrupted stitches, proper drainage is provided, and the wound of the integuments closed. The strictest antiseptic precautions are observed throughout, and the carbolized spray kept playing on the parts till the dressings are applied. In a number of cases the sac has been removed below the ligature at its neck, especially when it was found necessary to open it for the purpose of replacing its contents within the abdominal cavity. The time occupied in healing has varied from two weeks to two months; the average being about twenty-

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eight days. In many cases union took place without febrile reaction or other unfavorable symptom, but in a few it has been complicated with abscess, sloughing of integuments, etc.

Out of about seventy cases reported since 1876, by Annandale, Nussbaum, Czerny, Socin, and others, there have been but one death and six recurrences. Many of these operations, however, have been done so recently, as to render it impossible to judge as to the true proportion of recurrences.

Within the past two years I have operated on three cases,—two of inguinal and one of femoral,—in this manner. In but one, (inguinal) was the carbolized spray used. In each the sac was opened in order to replace viscera, and tied at the neck, but not removed. From three to five interrupted sutures were applied to the edges of the ring in each. Catgut ligatures were used in two cases; in the other, carbolized silk. The temperature rose from two to three degrees in each, and suppuration took place in all. All recovered in three, six, and seven weeks respectively. My first case (inguinal) was done nearly two years ago, and recurrence took place five months later, but was easily held by a truss, which could not be done before the operation. The second and third have remained sound for five and seven months respectively, and without a truss.

The following conclusions may be arrived at, after a careful study of the cases operated by this method, up to the spring of 1879:

1. In strangulated hernia, both femoral and inguinal, after relieving the stricture and returning the bowel, the hernial sac should be ligated as high as possible, cut through below the ligature and removed entirely. As an additional precaution, the edges of the ring may be brought together with interrupted sutures. Every antiseptic precaution must be observed.

2. In irreducible hernia, and in the reducible variety when a truss will not properly hold it back, this operation for radical cure may be performed with but little risk to the life of the patient.

3. In inguinal hernia, a truss should be worn as a precautionary measure after the operation, except perhaps in young individuals. In femoral cases this will seldom be required even in adults.

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INJURIES OF THE ABDOMEN.

By D. W. Hartshorne, M.D., Cincinnati, Ohio.

Mr. President, Gentlemen and Ladies of the American Institute of Homœopathy: Having been requested by the chairman of this bureau to prepare a paper upon "Injuries of the Abdomen; its walls; the alimentary canal, and the accessory organs contained therein," it gives me pleasure to present it to you for your consideration.

The frequent occurrence of injuries in this region, the importance of the viscus that may be involved, and the great danger which often attends them, makes their consideration of prime importance to us.

For the purpose of presenting the subject more in detail, I have classified them into contusions, with or without rupture of the internal organs; non-penetrating wounds, and penetrating wounds, either uncomplicated or conjoined with injury or protrusion of some of the organs referred to.

Contusions of the abdominal walls, from whatever cause they may arise, may produce various results.

They may cause severe shock and collapse, speedily proving fatal; or they may pass off without further ill consequences; or they may be followed by very acute peritonitis terminating in death.

In some cases the abdominal muscles are ruptured, the skin remaining intact, and the peritoneum uninjured. An injury of this kind, if the patient live, is very liable to be followed by atrophy of muscular tissue, and, at a later period, by ventral hernia.

Abscess occasionally results within the abdominal parietes from contusions.

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If the force exercised be great, rupture of some of the viscera may take place; this occurs in military practice, in the so-called wind contusions. In civil life it commonly results from blows, kicks, falls, passage of a cartwheel over the abdomen, or the squeezing of it between heavy bodies, as the buffers of two railroad coaches, which is a very frequent source of these injuries.

In this way the most fearful internal contusions and lacerations occur, the particular organ or organs injured, depending upon the location of the blow.

The organ that is most frequently injured in this way is the liver. This is owing to its large size, and the unyielding character and ready lacerability of its structure.

Of the other accessory organs, the spleen and pancreas, the spleen is by far the one most frequently crushed and torn.

Of the alimentary canal, the stomach most commonly suffers, especially if it be struck while distended with food; so also may any other portion of the canal be lacerated, as the duodenum, jejunum, ileum, and colon.

Persons who are thus injured, usually die in the course of a few hours, or at the furthest in two or three days, from shock and hæmorrhage into the abdominal cavity.

It is not usual for life to be prolonged sufficiently for peritonitis to ensue; but in cases that survive these conditions, it is the chief danger to be feared.

It is by no means of rare occurrence for the shock, of itself, to prove fatal.

I have witnessed several cases of this kind, in which the blow was received in the epigastric region.

One was from a blow with the fist; another from the kick of a mule; and still another from a fall, by striking upon the end of a post,—the shock in these cases amounting to complete collapse. This result is certainly a most remarkable phenomenon and is very difficult to account for, except that it is probably due to laceration or concussion of the great sympathetic nerve, and its large abdominal ganglia. Be this correct or not, to whatever cause we may refer it, it is certainly greater than that which follows a similar injury, unaccompanied by loss of blood, of any

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other part of the body except the central portions of the cerebro-spinal nervous system.

In cases of rupture of the solid organs, the liver or spleen, the shock may be maintained, and its severity increased by the syncopal effect of internal hæmorrhage, from which the patient usually dies.

We are not to conclude, however, that these injuries are in all cases speedily and necessarily fatal; though in rupture of the liver it may be and usually is so, when there is great extravasation of blood or of bile. So also in laceration of the spleen when the extravasation is internal to the peritoneum.

But that they are not always so, and especially when neither of these fluids are largely poured out, the following cases from practice will illustrate:

A man about twenty-eight years of age, a railroad employé, was assisting to make up a train, when he was accidentally caught and crushed between the buffers of two freight cars. I found him in an intense state of collapse. He seemed to be dying, but rallied after several hours. On the second day after the accident he complained of great pain and tenderness in the right hypochondrium. On percussion the dulness extended below the umbilicus. Symptoms of peritonitis of the asthenic type manifested themselves, and he became jaundiced. These were followed by great swelling of the abdomen, which soon became tympanitic. The peritonitis continued; the dulness, which only existed in the flanks after the tympanitic condition set in, increased, and fluctuation became apparent. No movement from the bowels took place for several days before his death, which occurred on the seventeenth day after the accident.

The autopsy revealed the thick border of the liver lacerated, but showing evident signs of its commencing to cicatrize. The intestines were matted together with lymph, which, together with the bilious fluid found in the abdominal cavity, amounting to fully twelve pints, was probably the cause of the obstructed condition of the bowels by pressure.

Several other similar cases have occurred in my practice, in which recovery took place. One of these I will describe, it being a typical one.

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A man about thirty-five years of age, by occupation a carpenter, fell from a scaffold, striking the right side of the abdomen violently against a beam. There was no evidence of injury in any other region. The shock was prolonged and severe, from which he slowly rallied. Peritonitis speedily developed, with great tympanitic distension of the abdomen. There was bilious vomiting, and colorless discharges from the bowels, and he became jaundiced. These symptoms continued for some days, when he began to improve. As the tympanitis subsided, dulness on percussion and fluctuation revealed the fluid, which was evidently extravasated into the abdominal cavity; he gradually recovered, the fluid being slowly absorbed. The vomitings, which had become less frequent, stopped. At the same time bile appeared in the stools, but it was several months before the tenderness over the region of the liver was gone.

In this case my conclusions were that the severity of the collapse, the seat of pain and injury, the peritonitis, the bilious vomiting, and the white stools, all pointed to serious injury of the liver; and that the rapid extravasation could only be accounted for by rupture of that organ.

The following case of rupture of the spleen occurred in the practice of a medical gentleman of my acquaintance. The injury was not suspected during the life of the patient, but was ascertained by autopsy. The history, which I obtained from the parents after the examination, presents several points of great interest.

In the early part of December, a young man between seventeen and eighteen years of age, while skating, fell on the ice, striking the posterior part of the left side of the abdomen. He made no allusions to the fall on his return home. After several days, however, he began to complain of chilly sensations in the left side and lower extremity. Notwithstanding this he was able to go about, but limped considerably, and felt weak and faint upon the slightest exertion.

This condition lasted until January 1st, when he was unable to leave the house, owing to increased weakness. Towards the latter part of January his condition became aggravated and he

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was compelled to remain in bed. Medical aid was now summoned, and the physician pronounced it a case of typhoid fever.

About five days before his death I was called in counsel. The attending physician stated to me that the young man had not been well for several weeks before he was called. He had been studying hard, but his parents did not think he had been overtaxing himself; that probably he had taken cold, and finally typhoid fever had set in.

He also stated that he had rheumatism in the left lumbar region and hip, the pain extending down the limb; he could not straighten it, or turn in bed.

These symptoms lasted two or three weeks, but finally gave way. He further stated that he suffered pain in the bowels; they were tympanitic, tender to the touch, but there had not been any diarrhœa, and the kidneys had performed their office satisfactorily.

The remedies which he had given were those usually indicated and prescribed in such cases. The diet had consisted principally of gruel, but now he was allowing him weak broth.

Upon examination I found the patient in a profound state of anæmia.

There was pallor of the whole surface, which was very marked in the face, especially the prolabia.

The surface of the body was cool, and he complained of chilly sensations.

The lower extremities, in fact the whole body was anasarcous.

The pulse was small, weak, and compressible.

Auscultation and percussion revealed œdema of the lungs, with effusion into both pleural cavities. The heart's action was irregular and labored, the sounds distant, with marked endocardial or bellows murmur over both aortic and mitral valves.

On percussion there was abnormal dulness over an increased area in the præcordial region, denoting pericardial effusion.

From my examination I was unable to confirm the diagnosis of typhoid fever; my conclusion was that it was a case of endopericarditis.

I was confirmed in this from the doctor's statement that the patient had rheumatism in the left lower extremity and loin.

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My conclusions were not satisfactory to the attending physician, so another gentleman, of considerable medical and surgical skill, was called in counsel.

I was not present, but was informed that his opinion was "that the heart was all right, but that his lungs were nearly gone."

The young man died on the 13th of March, about three months after he began to complain.

On the following day, in the presence of the attending physician and several other medical gentlemen, I made an examination of the body, when the following pathological conditions were revealed:

All the tissues, as well as the thoracic and abdominal organs, were abnormally pale.

The right pleural cavity contained two pints; the left, one and one-half pints of light straw-colored serous fluid. Both lungs were very œdematous and slightly injected.

The pericardium contained about one pint of fluid of the same character as the pleural cavities. The heart was flaccid; the endocardium was smooth, of a pinkish tinge, except in the region of the aortic and mitral valves, where it was considerably injected. There were a few small, rough granulations of fibrin and lymph on the aortic valve. About the mitral valve there was considerable exudation of fibrin and lymph partially organized, and quite firmly adherent to it, and to the chordæ tendineæ, and the contiguous tissue. The right ventricle and tricuspid valve were normal. In the abdominal cavity there was a limited amount of straw-colored serous fluid. There were slight adhesions of the viscera. There was no pathological lesion in the intestines. On the left side of the abdominal cavity, between the peritoneum and abdominal wall, was found a large coagulum of blood, four inches in width, one and one-half in thickness, extending from the spleen to the groin. On removing this and tracing it to its source, it was found to be extravasated from the spleen, which was found ruptured on its posterior surface.

The autopsy plainly showed that the congestion and œdema of the lungs, pleuritic and pericardial effusion, endocardial inflammation, and consequent exudations upon the mitral and aortic

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valves, and other cardiac structures, were dependent upon septic poisoning by absorption from the blood-clot, and that the anæmia was due to the combined action of the hæmorrhage, and the heart and lung complication.

The symptoms that attend contusions of the abdominal walls are first those common to shock, varying in severity according to the location and the force that causes it. Immediately following the shock there is swelling, change of color, tenderness, and pain upon pressure. If the blow be of sufficient force to cause rupture of the muscular tissue, the shock will be more severe, the swelling greater, and there will be fixed pain at the point of the rupture, the symptoms of peritonitis quickly setting in.

If abscess results we would recognize it by the inflammatory action, the induration about its base, and the characteristic throbbing or pulsating pain. If the force be sufficient to cause rupture of any of the internal organs that we have been considering, the symptoms will necessarily vary, according to the organ injured.

If it be the liver, there will be pain over its site; dulness on percussion from extravasated blood, and great collapse; followed, if the patient live, by diffused traumatic peritonitis, bilious vomiting, white stools, jaundice, and, at a later period, traumatic saccharine diabetes.

If the spleen has been lacerated there will usually be severe shock of the system, conjoined with symptoms of internal hæmorrhage, coldness, pallor of the surface, small feeble pulse, anxiety of countenance, great depression of the vital powers, and pain at the seat of injury.

When the stomach is ruptured the shock is very severe. If the patient survive it there is fixed pain in the region of this organ, with great anxiety and depression, quickly followed by peritonitis from extravasation of its contents. There is also vomiting, and vomiting of blood. This latter sign, however, is not always present, for cases have occurred in which the stomach has been torn across and no blood was to be seen in the vomited matters.

When the intestines have been torn there is shock, anxiety

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and depression, and fixed pain, quickly followed by peritonitis. In addition to these there is the admixture of blood with the stools, if the patient live long enough to pass any.

Another symptom, and one of great significance when it exists, is emphysema of the abdominal wall, and subsequently of the trunk. It usually commences in one flank, and may creep up towards the axilla, or in front on the abdominal wall. It presents the same doughy, puffy, inelastic, crepitating swelling of the subcutaneous areolar tissue as is met with in thoracic emphysema. It is valuable as a diagnostic sign in injury of the intestines, without wound of the abdominal wall, or if there be wound without protrusion of the injured part, as it shows that the alimentary canal has been lacerated, and that flatus has escaped.

It becomes necessary to determine when these conditions exist, whether we have a case of abdominal or thoracic emphysema, or putrefactive infiltration of air into the areolar tissue.

The absence of thoracic injury, and the site of the emphysema being in the posterior or lateral abdominal wall, would decide this point; while the cause, and the absence of low inflammation of the areolar tissue, would distinguish it from putrefactive infiltration with air.

The treatment of the various injuries that have been described is very simple.

The condition known as shock is usually the first one which demands our attention.

The patient should be placed in the horizontal position; and, in severe cases, brisk rubbing with the hands instituted, and pungent stimulating applications used.

Nitrate of amyl by olfaction is a powerful remedy, and will generally produce speedy reaction.

Alcoholic stimulation should always be avoided, no matter what the attending circumstances may be, for the succeeding depression will be more dangerous than the primary shock.

When the patient is partially restored to consciousness, or perhaps has never lost it, remedies will materially aid, or may alone accomplish, reaction.

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This result would be indicated by the change of color, the temperature rising, the pulse becoming more regular and stronger, the mind clearer.

Out of the long list of remedies which some authors recommend there are but few which my own experience would suggest as of any value; these are Arnica, Camphor, and Veratrum album.

Arnica mont.—When there is diarrhœa, with involuntary stools; involuntary urination; dizziness, with nausea.

Camphor.—When there is great coldness, with hot breath; the hands and feet tremble if he attempts to move them; tongue trembles if he tries to speak.

Veratrum album.—The patient is cold as ice; breath cold; tongue cold; expression of great anxiety.

After the immediate effects of shock have passed off, the reaction which ensues may not pass the limits of health. In other cases, however, and also in instances where the shock may have been but slight, a general febrile state arises, and may be of any degree of intensity, or of any pathological character, and dependent upon the general condition of the patient.

The treatment consists in the administration of Aconite, which, in a very large majority of cases, will meet the indications and be all that is needed.

If there be simply contusion of the parietes, with, perhaps, considerable hæmorrhagic effusion, Arnica is indicated, also Aconite, Belladonna, and Mercurius; Mercurius being the remedy which oftener than any other will arrest the formation of pus. But if suppuration seems inevitable, Hepar sulph. should be given to hasten it, and as soon as it has formed, it should be evacuated either by aspiration or free incision, both because of the tendinous structure by which they are covered, and of the possibility that it might break into the peritoneum. After its evacuation the character of the discharge will point to the appropriate remedy. The most prominent ones are Arsenicum, China, Iodine, Pulsatilla, Silicea, Sulphur.

In rupture of the recti, or other muscles, the shock, hæmorrhagic effusion, inflammation and suppuration, if they arise,

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must be met in the manner and with the remedies heretofore pointed out for those conditions.

In all injuries of the abdomen, its walls or viscera, which we are considering, the patient should be placed in a position to relax the parts as much as possible. This is best accomplished by placing the patient on the back, with the head and shoulders raised, and the thighs flexed on the abdomen, supported by pillows.

We relax the parietes, because in cases without rupture we prevent or relieve to a great extent the tension and consequent suffering incident upon the inflammatory swelling, and in cases of rupture we effect a closer approximation of the wounded muscle, thus obviating as much as possible by these means the tendency to hernia.

Nevertheless all wounds of the abdominal parietes, of whatever name or nature, that involve the muscular tissue, must be considered as predisposing to hernia, and measures must be taken to prevent such an occurrence.

We need not look in the direction of remedies to prevent extrusion; therefore, as soon as the inflammatory condition will allow, the parts should be supported by a compress and bandage, to retain the viscera within the abdominal cavity until the lesion has healed, and the parietes have regained their tonicity; after this a well-fitting truss must be applied, with a spring just strong enough to effect the desired end, and with a pad which extends for some distance beyond the margin of the outlet.

We must be careful about the pressure, as too much will increase atony and may induce absorption and attenuation, while too little will fail in securing retention.

Incised wounds of the abdominal wall that simply implicate the integument, are of no great importance; they only need the application of adhesive plaster to keep the edges in contact until union takes place. If the muscular or tendinous structure be involved, sutures should be used that include not only the integument but all the incised tissue, because when thus applied they prevent extrusion of the viscera during the healing process, and effect a closer and firmer union of the tissues by exciting a more abundant effusion of plastic matter.

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During the healing process attention should be given to position, so as to keep the parts relaxed, and after the wound has healed, no matter how firm the cicatrix may appear, it should be supported by a bandage or truss, to prevent hernial protrusion.

If the wound penetrate the abdominal cavity without injury or protrusion of the viscera, the same treatment should be instituted. When the intestine is wounded but does not protrude, the existence of this further injury will be manifest by the escape of fetid air, or of fecal matter from the external wound, and at a later period by the discharge of blood with the stools.

But an injury of the gut when it lies concealed in the abdomen does not always admit of being immediately diagnosed with certainty. In a large majority of cases there is at first no escape of air or of the contents of the bowel from the external wound, and the discharge per anum will be very limited, and this does not occur for a certain time after the injury.

Wounds of the small intestines, especially of the duodenum and jejunum, are usually followed by great anxiety, paleness of the face, syncope, cold perspiration, and a small, intermitting, tremulous pulse. But these symptoms are very equivocal; they furnish no positive information, because a superficial cut or unimportant wound is frequently attended by similar symptoms in nervous, irritable, or timid persons.

Our inability, however, to diagnose positively in every case whether the bowel be injured or not, is of no great practical importance, because even when the severity or peculiarity of the symptoms do not make the nature of the injury clearly manifest, or if the symptoms leave no doubt, the general management will not materially differ.

Wounds of the small intestines are more dangerous than those of the large, and the nearer the injury is to the pylorus, the greater the danger. They are also much more liable to extravasation.

When the large intestines are injured, the symptoms are not as severe. This may be due to their being more fixed, and consequently when their contents are extravasated through a wound in them it finds a more ready outlet. Perhaps their greater ca-

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pacity secures a more certain passage of their contents towards the anus, hence extravasation does not take place.

Extravasation of the intestinal contents into the peritoneum is undoubtedly one of the greatest dangers that can occur in wounds of the abdomen, for the peculiar irritating qualities of the fecal matter excite and keep up intense peritonitis. Fortunately, however, it does not occur as frequently as might be expected.

If the wound in the intestine be small, not more than two or three lines in extent, eversion or prolapsus of the mucous membrane will take place, so as to close it sufficiently to prevent the escape of its contents. Besides this, when we speak of the cavity of the abdomen, we should bear in mind that, strictly speaking, no such empty space exists. The whole of the visceral contents are so closely and equally brought into contact by the pressure of the abdominal muscles and the diaphragm, that it requires considerable force for the intestinal contents to overcome this uniform support, and to insinuate themselves between the coils of the intestines.

Hence, except under peculiar circumstances, though the bowels may be wounded, extravasation is generally prevented, or, when it does occur, the effused matter may lie all in one mass, and become circumscribed by adhesive inflammation. In fact all the surfaces in contact with each other, and surrounding the track of the wound, become so closely connected by the adhesive inflammation, that the wound forms a sort of canal, entirely destitute of all communication with the peritoneal cavity; and it is astonishing how rapidly such adhesions take place, requiring only a few hours, thus demonstrating what a salutary process this adhesive inflammation is, which afterwards renders the occurrence of extravasation quite impossible, or bounds or circumscribes the effusion, if it has already taken place.

Mr. Travers, who is good authority, was of the opinion that the only circumstances under which an effusion of the intestinal contents can occur is if the gut be very full and the wound extensive.

In such a case the surrounding pressure is overcome by the natural action of the bowel, tending to the expulsion of its contents, but in defect of either of these states effusion cannot occur.

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When, however, air has escaped from the bowel, or blood has been extravasated in any quantity within the abdomen at the time of the injury, the resistance made to effusion will be less effectual, although the pressure of the sides of the abdomen be the same, as fluids yield more readily than solids naturally in contact.

In the treatment of this class of cases we must endeavor to prevent extravasation of feculent matter, and limit the peritonitis that will ensue.

The patient should be placed in a position to allow the extravasated fluid to readily escape through the wound, which is to be left open, or, if very extensive, at least the most dependent portion of it. A bandage should also be applied around the body to aid the muscles, by its pressure, to prevent or limit extravasation.

If, however, the wound be about the umbilical region the patient should lie on the back, with the limbs flexed, to relax the abdominal wall, which should also be supported by compress and bandage.

Another very important practical point in the general management is to give a remedy to assist nature in her effort to repair the injury. One of her first endeavors is by the effusion of plastic lymph to glue the contiguous parts together, thus arresting peristaltic action, the continuance of which would favor extravasation and consequent peritonitis, and interfere with the closure of the wound by hindering its agglutination to the neighboring parts.

Opium has the power of controlling peristaltic action, and with this end in view should be given, and repeated often enough to keep up its action, until nature has completed her own method for arresting it.

The patient should be prohibited from making any effort. The urine should be drawn twice every twenty-four hours. The bowels should be left undisturbed for eight or ten days; if at the end of that time no movement takes place an enema may be given to move them. No food should be allowed for the first three days; during this time barley-water and ice should be freely given. After this, beef tea and light food, that leaves no solid

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matter, may be taken. It is of great importance that no solid food be given for two or three weeks after the injury.

If, instead of the condition just considered, there be penetrating wound of the abdomen, in which protrusion of uninjured intestine, mesentery, or omentum take place, the sooner it is returned the more effectually will the irritation arising from its exposure and constriction be prevented. This protruded mass is always very large in comparison with the aperture from which it escapes, and is often difficult to reduce. In reducing it we should adopt the long-established rule, which is, to return the mesentery before the intestine, and the intestine before the omentum. The last protruded portion of each of these parts should be first reduced.

Care must be taken to completely return the protruded mass into the abdomen, and that it is not pressed up into the sheath of the rectus, or between the layers of the abdominal muscles, or into the subserous areolar tissue lying in front of the peritoneum; an accident of this kind would be fatal, as the constricted neck of the protrusion would be unrelieved.

In order to effect reduction easily the abdominal walls should be relaxed by flexing the thighs upon the abdomen, when we may gradually push back the protrusion by steady pressure. We must not, however, employ any force or rough handling of the delicate parts. If they cannot be readily returned, owing to the constriction of the neck of the tumor, the aperture through which they have escaped must be carefully enlarged in a direction upwards; the incision need not exceed half an inch in length, and should be made with a probe-pointed bistoury, or hernia knife.

If the intestine be already inflamed its immediate reduction is, beyond all question, the right practice. Even though the inflammation is severe its immediate reduction will often prevent gangrene. The dull, brown, dark-red color of the protruded intestine may lead us to fear that it is already gangrenous, or that gangrene is inevitable. Its firmness, however, will determine that it is not in a state of gangrene, and its reduction should be immediately effected.

If from exposure and constriction the intestine has become

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gangrenous, reduction should not be attempted, but an incision should be made into it, so as to allow of the escape of fæces and the formation of an artificial anus. If the omentum be inflamed it should be returned, but if it be gangrenous it should be incised on a level with the peritoneum. After it has been incised, and any bleeding vessels secured, it should be returned, unless it has contracted adhesions; in such a case it may be left to plug the wound and hinder a future hernia.

If the intestine that protrudes be wounded the aperture will call for special attention.

Formerly surgeons were somewhat divided as to the question of the propriety of stitching it up. Some were opposed to it, on the ground that it does not prevent extravasation of feculent matter, and that the stitches produce irritation by acting as foreign bodies. They propose to return the wounded gut, taking care, however, to leave the aperture in it opposite to that in the abdominal wall, so that an artificial anus might form by adhesion of the edges of the openings to one another, and by that means prevent extravasation.

The objection to this practice is that extravasation will occur before there is time for the effusion of lymph and the adhesion of the contiguous surfaces; besides the wounded intestine is very liable to change its position after being reduced, hence there is no certainty of securing the necessary relation between the two apertures, and further, experience has proved that the objection against stitches not being able to prevent the extravasation of feculent matter is not valid, and that they act as sources of irritation to any extent is very doubtful. For it is found that, when a wound in the intestine is stitched together and returned into the abdomen, the stitches are quickly coated over with a thick layer of lymph, and they gradually ulcerate their way inwards and drop into the bowel, and are expelled per anum, leaving a firm cicatrix at the point to which they are applied.

For these reasons stitching up the wound in a protruding intestine, in suitable cases, is the proper practice, but it is evident that no positive and unvarying rule can be laid down that will apply to all cases. If the wound in the gut be very large and transverse, the result of a gunshot or other contusing force, it is

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very evident sutures would be of no avail, for it not only might be difficult to bring the edges together, but they probably would not adhere to each other if we did, nor to the abdominal wall, but if it be an incised wound it is the right thing to do. In cases to which the suture is applicable, much will depend upon the way in which they are applied. They should be introduced by means of a fine round needle, in such a manner that only the peritoneal surfaces on each side of the wound are brought into contact, for adhesion only takes place between these, the wound in the other structures filling up by plastic matter.

This is accomplished by entering the needle on one side of the wound three-sixteenths of an inch from its edge, and bringing it out one-sixteenth from the edge of the wound on the same side, then entering it on the other side of the wound one-sixteenth of an inch from the edge, bringing it out two-sixteenths of an inch beyond. After the surfaces included in the stitch have been brought into contact and tied, the thread should be cut close to the knot, when they quickly become covered with lymph, and finally find their way into the interior of the gut, and are disposed of in the manner heretofore mentioned.

The aperture closed, the intestine should be cleansed with lukewarm water and reduced. If, however, the protruded gut be too extensively torn, and especially if it be lacerated by a gunshot, it would be useless to stitch it up. It should be cleansed and gently returned, care being taken not to push the wounded part far into the abdomen, but to leave it close to the abdominal orifice, so that in the event of extravasation taking place, or the stitches giving way, a ready outlet is afforded.

The intestine reduced, if the wound in the abdominal wall be extensive, it should be closed by sutures and adhesive plaster, and supported by a compress and bandage, a portion, however, being left open to allow of the escape of extravasated matter.

Injuries of the stomach may be supposed, from the location and direction of the wound. The usual symptoms are vomiting, and vomiting of blood, escape of the food, fixed pain in the region of the organ, together with anxiety, depression, and all the other symptoms that attend penetrating wounds of the abdomen.

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If the external wound be large a portion of the stomach may protrude through it.

Wounds of the stomach are always very dangerous, extravasation and inflammation being special sources of danger.

The danger is increased if it be wounded while distended with food, and especially if the wound be in the curvatures rather than in the centre of the organ.

The treatment of wounds of the stomach does not differ materially from wounds of the intestines. If the organ protrude through the external wound, and, upon examination, it be found wounded, it should be stitched and returned, and the external wound also closed. If it do not protrude, and food escape through the external wound, it should be kept properly open.

If the wound in the stomach can be discerned through the external wound, its edges should be stitched to the edges of the parietal wound, which may also be closed after adhesive inflammation has made extravasation no longer possible.

No food should be allowed by the mouth for from eight to fourteen days, the patient being supported by nourishing enemas until the edges of the wound have become glued to the adjacent parts, and the condition of the stomach will permit. To allay thirst crushed ice, also rinsing the mouth and bathing the body should be prescribed.

Injuries of the liver may be presumed from the depth and direction of the wound.

They are much more frequent in military than in civil life, and vary in their nature, site, and extent. They are generally attended with considerable hæmorrhage, and are always regarded as serious accidents.

If they penetrate deeply into the substance of the liver it is impossible for some of the branches of either the hepatic artery, portal vein, or hepatic vein, to escape being wounded. Hence it is easy to understand why severe hæmorrhage is liable to occur, and if a large vascular trunk be involved that they speedily prove fatal.

The symptoms are often obscure. The most reliable ones are fixed pain, and a feeling of weight in the region of the organ,

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with a discharge of black blood mixed with bile, or it may be bilious matter of a yellowish or greenish color, perhaps very thin and of a viscid character.

Besides these symptoms there is generally nausea and vomiting, great thirst, restlessness, and great prostration, often amounting to complete collapse.

If the patient survive for a length of time the eyes, skin, and urine become jaundiced. If there be wound of the gall-bladder without wound of the liver, the discharge from the wound will be pure bile. When the gall-bladder is accidentally adherent to the peritoneum the bile will escape externally and a biliary fistula remain, but if the bile become extravasated the abdomen quickly swells and fluctuates, respiration becomes difficult, the pulse small, quick, and compressed, the extremities cold, and the countenance very pallid. There is also obstinate constipation with retchings and vomiting, and the patient soon becomes jaundiced. This extravasation of bile is held as substantially fatal.

The treatment of wounds of the liver consists in placing the patient in such a position that the extravasated matters can escape from the wound, and in applying the proper bandage around the abdomen, the patient being kept as quiet as possible and the diet properly restricted.

Wounds of the spleen do not occur as frequently as those of the liver, though they closely resemble them in character and in the manner of their production. They usually result fatally, rather on account of hæmorrhage than the severity of the resulting inflammation, the patient rarely living long enough for peritonitis to be set up.

The symptoms by which we are able to form an opinion in the case are, the location, direction, and depth of the wound, the fixed nature of the pain, and the great pallor of the countenance indicative of internal hæmorrhage.

The treatment consists in keeping the patient quiet, and if the hæmorrhage be great the local and internal use of ice will be of service after recovery from the shock.

If the wounded organ protrude from the external wound or lie within the lips of it we may return it if the wound in it

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be slight, but if upon examination the wound is found to be large and disposed to bleed freely it must be allowed to remain in its impacted position, where the hæmorrhage will be controlled by the pressure of the lips of the external wound.

If the splenic artery has been wounded the ligature must be applied, even though it require enlarging of the external wound to a considerable extent.

In case the protruded portion of the organ be in a state of severe inflammation from its having been protruded for several days, the proper treatment is to incise it on a level with the surrounding surface, or it may be removed by ligature, which is the safer plan. The propriety of this method has been demonstrated by reports of many cases in which it has been successfully adopted.

When the alimentary canal, the stomach, or intestines, or its accessory organs, the liver or spleen, are lacerated by blows, kicks, falls, or by being tightly jammed between hard resisting bodies, the shock is often appalling, and the majority of cases die in a few hours, or at most in a few days. Nevertheless I have nothing to add to what I have already said in regard to its treatment.

Neither have I anything to add to the treatment pointed out for the subsequent reaction.

The great object is to limit inflammation by the most perfect quietude and a careful restriction of the diet.

Traumatic peritonitis constitutes the great danger to be apprehended in all serious injuries of the abdomen, and it is this affection which so frequently proves fatal, death seldom resulting from hæmorrhage unless one of the large vessels has been wounded.

A certain degree of inflammation is necessary for the repair of the injury, but it must be limited in extent and of a plastic character. When it departs from this and assumes the diffuse form, attended by the exudation of turbid serum and shreddy ill-conditioned lymph, it proves speedily fatal, often within a few hours after the injury.

The symptoms indicative of the existence of the disease are unmistakable.

The patient lies on the back with the limbs retracted, in order

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to relieve the tension of the abdominal muscles; great pain and tenderness, at first circumscribed, afterwards diffused, exist; the breathing is hurried, short, and thoracic; the pulse is frequent, small, hard, and wiry; the bowels are constipated; the stomach is nauseated and rejects its contents, not by vomiting but by regurgitation; the eyebrows are knit, and the whole countenance is expressive of great suffering; the thirst and restlessness are intense, and there is usually considerable fever, often preceded by severe rigors. Death generally occurs in from thirty-six to forty-eight hours.

If copious hæmorrhage has occurred there will be, in addition to some or all of the other symptoms, deadly pallor of the countenance, great feebleness of pulse, and most distressing prostration, with excessive thirst and intense præcordial anxiety.

In the less acute form of the disease life is prolonged for several days or weeks, effusion of turbid serous fluid taking place in the peritoneal cavity. As this effusion increases dulness on percussion will manifest itself, first on the flanks and then gradually extending forward, until it may occupy a great extent of the abdomen.

In the treatment of this affection the character of the inflammation will be the guide for the selection of remedies. If it be of the sthenic type, and the patient young and robust, Aconite should be given internally, and fomentations of the same remedy applied freely to the surface of the abdomen.

The most rigid diet should be enforced, and the patient kept perfectly quiet and free from excitement.

The remedies which will be found of the most value in the treatment of this disease are: Aconite, Apis, Arsenic, Belladonna, Bryonia, Cantharis, Lachesis, Mercurius, Opium, Rhus tox., Sulphur, and Veratrum.

Aconite.—For hot, dry skin, quick and hard pulse, tongue and mouth dry, great thirst, bitter taste, constipation, scanty, high-colored urine, restlessness, cutting, darting pains in the bowels, increased by pressure, great heat of the abdomen.

Apis.—Burning, stinging pain in the bowels, very sore to the touch, with swelling of the abdomen, dark scanty urine, vomiting of bile, diarrhœa.

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Arsenic.—Later in the disease sudden sinking of strength, cold clammy perspiration, continued thirst, small quantities satisfies; burning in the abdomen, hard, bloated abdomen; thin, watery stools; symptoms worse at night.

Belladonna.—Congestion to the head, colicky pains in the bowels; painful retchings and vomitings; pains increased by motion; great anxiety.

Bryonia.—Stitching, pressing lancinating pains in the abdomen, increased by motion, after exudation has taken place; tongue white and dry; great thirst, and drinking large quantities at a time; bowels constipated.

Cantharis.—Burning, hot abdomen; tympanitis; bloody stools; tenesmus of the bladder; strangury; restlessness; distressed face, sunken features, and cold extremities.

Lachesis.—Abdomen hot and sensitive to touch; nausea and vomiting; great thirst; cannot bear the weight of the clothes; scanty turbid urine; constipation.

Mercurius.—At a later period creeping chills, perspiration without relief; slimy stools, with straining; swelling of abdomen; weakness of digestion and pain in region of liver.

Rhus tox.—Great restlessness; tongue red at the tip; pressing, cutting pain in the abdomen; typhoid symptoms.

Sulphur.—When the disease is protracted and remedies seem to be ineffective.

Veratrum.—Vomiting and diarrhœa after the least food; coolness of the skin; cold sensations of the mouth; great thirst; weak, small pulse; restlessness and anxiety; cutting pain in the abdomen as with knives; bowels hard and bloated.

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PROLAPSE AND FOREIGN GROWTHS OF THE RECTUM.

By E. C. Franklin, M.D., Ann Arbor, Mich.

The subject before us comprises some of the most interesting and possibly the most frequent diseases that affect this important viscus, when we consider that at every motion of the rectum that involves the normal evacuating of its contents, the lax mucous membrane of the intestine during the discharge is protruded, and, to a certain extent, its muscular coat assists in propelling the fæces onward and through the anus. While this muscular action is going on the extrusion of the bowel takes place, which, as soon as completed, returns to its normal position again, to undergo like movement whenever defecation occurs. When, however, from abnormal conditions during the process of evacuation, this movement is prevented, certain morbid manifestations occur, among which may be denominated "prolapsus of the rectum." The mucous membrance protruding beyond the anus becomes constricted, its circulation is impeded, congestion, swelling, and pain ensue, its attachment to the connective and muscular tissue, normally lax, becomes more and more weakened, till all control of the membrane is lost and it remains protruded for lack of vital contractility to return it to its position. During this time œdema takes places in the extruded membrane; the parts become thickened, irritation extends towards the intra-anal portion, and the submucous and connective tissues, from their loss of nervous retentivity, and the whole lower portion of the bowel being implicated, participates in the prolapse. This last degree of prolapse is frequently seen in scrofulous children and in those whose systems have suffered from previous constitutional impairment or local derangement of the rectum. If the prolapse con-

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tinues for a considerable length of time, the inertia of the nervous influence at the point constricted merges into partial, and sometimes complete, paralysis. This disease is an affection of childhood, but occasionally occurs in old age, when it assumes a serious aspect from the magnitude of its proportions. In a case of the latter kind, which came under my observation some three years ago, in an aged person of impaired constitution, the descent of the bowel was so great as to produce death by consequent derangement and irritation of the system. It was reduced three times, but so great was the propensity to extrusion, that not even a T bandage and roller would retain it in position. Medicines effected little or no good, and the patient sank from exhaustion.

The protruded gut in children forms a tumor of an oblong and cylindrical shape; the surface of the mucous membrane is smooth and vascular, the vasa vasorum being distended with blood, which gives it a bright-red color and covered with mucus. It occurs most frequently in children as the result of protracted diarrhœa, and, as a rule, when the diarrhœa abates, the extruded bowel gradually contracts, and as the child regains strength it passes again into the anus and becomes rectified. This is the favorable result in such cases, but often it assumes an obstinate mood and refuses entirely to return within the anus. When the disease has existed for some time, certain changes result with the following characteristics: A ring of thickened integument occupies the external portion, and thickened flaps of mucous membrane, assimilating integument, hang down in various shapes and lengths, the portion which has been longest protruded being the thickest and least sensitive. At the orifice of the gut the parts are less changed in appearance, the mucous membrane preserving, in a large degree, its appearance and texture. In some cases patches of ulceration are seen in the constricted portion, where they have been lying in contact, with more or less mucus thrown off from the abraded membrane. In aged persons these tumors, when they have been protruded for a long time, become quite large, and the mucous membrane partakes more of the consistence of leather than mucous tissue. In such patients the sphincter relaxes and leaves a patulous entrance into the rectum,

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which permits easy egress to the relaxed bowel. This state of things gives rise to hæmorrhoids, which increase the extent and severity of the disease, so that at each defecation these pile tumors become more and more protruded, till we have a mass of pendulous structures, composed in part of the extended bowel and part of distinct and enlarged hæmorrhoidal growths. The inconvenience and suffering attending the disease when carried to such an extent are very considerable, extending to the bladder and urethra, and creating great distress in these organs. Retention of urine is almost always an accompaniment of the disease, and great distress and bodily discomfort wear down the vigor of the patient and engender complications that are not unfrequently fatal. When the disorder increases slowly and almost imperceptibly, at first the patient feels only a little discomfort during defecation, and perhaps he may push back the protruded intestine, and no further trouble be occasioned till the next movement, when it will be pushed down a little further; more and more difficulty being experienced on the part of the patient from time to time, till the extent and severity of the disease become a matter of extreme solicitude on the part of the sufferer. In some cases sloughing of the protruded parts takes place, and in this way a cure is effected, but not without considerable danger.

Sometimes it occasionally happens that the muscular coat descends with the mucous membrane, when invagination of the rectum takes place, which constitutes a different and far more serious condition than the ordinary prolapsus. The mark of distinction between these two conditions is evidenced by the following characteristics. In prolapsus, the mucous membrane covering the extruded ring will be found continuous with the sphincter ani, while in invagination, which is compatively infrequent, there is a distinct and deep sulcus between the protrusion and the margin of the sphincter.

Etiology.—The causes of prolapsus are twofold, *constitutional* and *local.* Children who suffer from digestive irregularities, affections of the urinary organs, of a debilitated and lax fibre, who have been enfeebled by insufficient nutriment, impure air, improper hygienic influences, and those who are affected with stone in the bladder, ascarides, or hæmorrhoids, are extremely

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prone to this affection. The frequent employment of enemata in adults, constipation, enlargement of the prostate, sedentary occupation, chronic tenesmus, irritation produced by stricture, etc., are fertile causes of this disease. In other cases it is frequently associated with piles, the long-continued irritation weakening the tone of the nerve-power distributed to the internal coats of the rectum, and finally the dragging downwards of the mucous membrane by the constantly increasing weight of the hæmorrhoidal tumors.

Treatment.—The *curative* treatment of this affection depends in the first place on the removal of the causes producing it; and, secondly, in the *palliative* process of reducing the extruded bowel, which is the first duty of the practitioner to perform. This in the recent state is readily accomplished, except in very young children, who complicate the operation by their cries and violent struggles. The protruded bowel should be first painted over with olive oil, cerate, or fresh lard. The fingers, being also well lubricated, are made to grasp the tumor gently and firmly, and by continued pressure empty the congested vessels, then pressing cautiously inwards and upwards it may be returned. If the tumor has been large, and the child is restless and uneasy, it will be apt to protrude again. In such cases anæsthesia should be produced, the bowel be returned and held *in situ* by a single roller-pad or folded towel, well greased, and all held in position by the ordinary **T** bandage. At this juncture rest in the recumbent position should be rigidly insisted upon. The foot of the bed should be well raised, so as to induce the unloading of the bowel by gravitation towards the heart. This simple expedient I have found of much value, especially in those of lax, debilitated habits, with large bellies and cachectic systems. After the return of the bowel I have employed *Belladonna* unguents, applied to the pad or roller and held firmly against the anus. In one case, where the protrusion was exceedingly difficult to retain on account of continued straining at stool, I overcame this condition by smearing the parts to be returned with an ointment of Belladonna. After the replacement of the bowel either of the following remedies may be given according to their pathogenesis: *Indigo, Ignatia, Nux vom., Podoph., Hamamelis, Carbo veg.,*

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Merc. cor. To remove the predisposition to this affection I have employed with much benefit *Arsenicum*, *Calcarea*, *Phosphorus*, *Lycopodium*, *Ruta grav.*, *Sepia*, *Silicea*, *Thuja*, and *Sulphur*. These remedies possess a powerful control over this disease in restoring the weakened forces of the protruded membrane, and in giving tonicity to the relaxed tissues. The diet of the patient should be of the blandest materials; the horizontal position should be insisted upon for several days, and the bandages kept on to prevent the recurrence of the disease. In those conditions in adults, when the mucous membrane is so thickened and debilitated that it cannot be retained within the anus, it has been advised to *remove* the loose and pendulous flaps. A modification of the operation proposed by Dupuytren consists in seizing by the forceps a fold of the skin on each side of the anus, and with a sharp, curved pair of scissors remove in radiating folds both skin and mucous membrane. As the wounds heal the cicatricial surfaces act as so many bridles of adhesion, contracting the tissues and holding them in position within the anus. By this means the bowel is drawn up, the anus permitted to contract, and the prolapsus is radically cured.

After the replacement of the tumor the predisposition to extrusion may be prevented by the use of properly selected remedies and the adoption of rigid dietetic rules. In certain chronic cases a pessary or spring pad has been employed with great relief as a palliative measure.

Another and a more simple procedure of curing prolapse is the *ligature*. Its application is especially adapted to such cases as involve great laxity of the mucous membrane without involvement of the surrounding integument, and where there exists hæmorrhoidal tumors. It can be readily performed by pinching up with a pair of forceps small portions of the diseased membrane, throwing around them a ligature and cutting off its extremities, and returning the mass within the sphincter. Strangulation of the ligated portions occurs and sloughing ensues, and the cicatrix acts as a bridle to hold up the membrane from further extrusion.

In certain rare cases a portion of invaginated bowel protruding through the sphincter has become strangulated, with all the at-

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tending conditions that follow such a constriction. In such instances an attempt must be made at reduction, and, failing in this, division of the sphincter must be accomplished.

Foreign Growths in the Rectum.—Of chief importance among the foreign growths in the rectum cancer may justly be considered the most frequent and prominent. Essentially of a malignant character it expends its peculiar characteristics not only locally, but it may involve the inmost recesses of the entire organism. Like other portions of the body that are subject to this malignant formation, cancer, in its *three* principal forms of *encephaloid, colloid,* and *scirrhus,* invade the tissues of the rectum, until, by increased cancerous deposit, contraction and narrowing of the canal take place, oftentimes to an extent that entirely interferes with the expulsory function of the intestine. Fungous masses spring out from the mucous membrane of the bowel, project into and completely occlude and block up the cavity of the rectum. It may attack any portion of the rectum, but by preference invades the *lower* portion, most frequently at a point less than three inches from the orifice of the anus. It begins in its earliest stage usually as a dense, almost cartilaginous, nodule, occupying the intrarectal areolar tissues, and in the course of its development it pushes outward the mucous membrane so as to form a large tumor within the cavity of the rectum. Rarely it attacks the connective tissue between the muscular and serous laminæ of the intestine, and its multiplying deposits penetrate into and between the fibres of the muscular coat. In this variety a general thickening and induration of the whole structure of the bowel take place, all the tissues being incorporated into one diseased and degenerated mass, and obliteration of the cavity of the rectum occurs as in the foregoing variety. In other cases the changes that take place assume more the characteristics of disintegration and softening, by which means destruction of the rectal coats ensues, thereby increasing the calibre of the canal in all directions. When it attacks the connective tissue of the serous coat it often expends its destructive and disorganizing influence in the extrarectal structure, and the intestine becomes wedged in the pelvis, agglutinating together all tissues that it comes in contact with, producing a huge mass of disease lying deep down in the

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perineal region, and involving the vagina in the female, the bladder and urethra in the male.

As in stricture of the urethra, when the canal is contracted at any portion of its extent, the intestine above becomes dilated and hypertrophied. Cancer begins, as a rule, so insidiously, as not to be suspected, until a considerable change has taken place in the condition of the intestine. The patient is troubled with flatulency and uneasiness about the lower bowel, difficulty in passing the contents of the bowel, straining at every movement, a sensation of pain and weight in the bowel, as if the intestine had not been entirely relieved, together with the discharge of blood, mucus, or pus, and flattening of the fæces. These are the symptoms that show the early development of stricture dependent upon induration, and thickening of the structures invaded. As the disease advances, the difficulty of voiding the fæces becomes greater; more pain is experienced, in consequence of the passage of the fæces over the raw and ulcerated surface, which is marked by the discharge of blood during each motion. A greater or less degree of distension is felt in the bowel, which is occasionally relieved by a profuse diarrhœa. On exploration of the bowel with the finger, its lower portion will be felt considerably expanded, and pushing its tip upwards, there will be felt the contracted, hardened, and nodulated mass. The pain, as the disease increases, loses its localized character of a burning heat, and now is felt radiating towards the loins, back, and down the thighs, and is of such severity, that the sufferer looks forward to each movement of the bowels with dread, and restrains the action as long as possible. The general health, which was not influenced to a marked degree at first, now begins to show the effects of the disease upon the system, the whole nervous organism participates in the toxæmic condition, the face assumes an anxious expression, the spirits are depressed, sleep disturbed, digestion impaired, and the countenance wears the aspect of one suffering from a deeply seated malignant disease. As the disease increases, so does the suffering, till the patient presents the most pitiable and deplorable condition, and at last he sinks away, worn out by continual pain, the system poisoned, the blood contaminated with the products of the cancerous products. If com-

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plete obstruction does not accelerate a fatal termination, other complications ensue, fistulous openings are established between the rectum and urethra or bladder in the male, or into the vagina in the female, and fecal liquid discharges are forced through these openings, increasing the misery of the patient, and rendering him an object of loathing to himself, and disgust to his friends. At times an abscess is developed into the peritoneum, which discharges its contents into the abdomen, and produces peritonitis and death. It has been observed by a late authority that the higher up the cancerous disorganization is developed in the rectum, the less severe is the patient's suffering, and *vice versa.* This is supposed to account for the differences of the sufferings in such cases, and the constitutional derangements that attend the development of this disease, whether at the sphincter, or high up in the intestine.

Cancer of the rectum is a disease of middle life, say from thirty to sixty years of age, occurs more frequently in males than females. Of seventy-three cases treated by Dr. Thomas B. Curling, F.R.S., of which notes were preserved, fifty-seven were males and sixteen females. In one case, treated at the London Hospital, the patient was a young man under twenty-one years of age. This is the earliest age Dr. Curling has ever met with the disease.

Death usually occurs within three or four years after its symptoms are fully developed, and is produced either by a complete obstruction of the rectum with its attendant manifestations, or by a gradual implication of the system, and a consequent sinking of the vital forces.

Treatment.—The most success attending the treatment of cancer of the rectum is when the disease is first discovered, and before any great amount of disorganization of structure is developed, and here the superiority of homœopathic therapeutics is shown in contrast with that old-school treatment, which "can offer no other service, unfortunately, than that of palliating the disease, assuaging pain, and prolonging the duration of life." Says another recent author: "All that can be obtained from remedies is palliation of the symptoms, ease from pain, and support under the wearing effects of this terrible disease." I pro-

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pose to show that, notwithstanding this testimony of the regular school, there are cases, and by no means few in number, that are permanently cured by homœopathic remedies.

In the early stages of the disease I have succeeded in curing a number of cancerous diseases of the rectum, and other parts of the body, and the remedies that have proved of most value in the treatment of this disease are the following: *Arsenicum, Arnica, Arsenic. iod., Aurum, Belladonna, Carbo an., Causticum, Cicuta, Calc. arsen., Conium, Chimaph. umb., Calc. iod., Conium, Cundurango, Graphites, Hydrast., Kreosotum, Galium ap., Lachesis, Mercurius, Murex purp., Nitric acid, Phenic acid, Phytolacca, Silicea, Robinia pseud., Solanum nig., Thuja.* I shall refer the reader to the pathogeneses of these several remedies, that the proper one may be selected for internal use and external application. The broad principle of cure lies before us, and I accept the proposition that cancer of the rectum is, in a large majority of cases, curable. I will mention only a single case, where the patient was placed under skilful allopathic hands, and the disease was pronounced "carcinoma of the rectum," and I most certainly believe the diagnosis was correct. H. F. came to my office for consultation, in reference to a disease he was then suffering from, and requested relief if possible. Examination proved the existence of cancer of the rectum, about three inches above the sphincter. The tumors were hard and nodulated, attended with burning pain, a sense of fulness and weight in the rectum, considerable straining at stool, and the fæces slightly flattened during motions. The diagnosis of the previous physician as to cancer was entirely confirmed. I proposed to treat the case, and if possible to effect a cure. My treatment consisted in local applications of *Chimaph. umb.*, and *Galium aparine*, and internally *Arsenicum, Cicuta, Mercurius cor.*, and *Hydrastis*, as indicated. My notes on the above case are exceedingly meagre, and are taken from my daily diary. The case was reported cured, and it is several years since I heard from him, but the last letter was confirmatory of the successful result of the case. I have employed *Carbolic acid*, in connection with the *Senecio vulg., Galium*, and *Chimaph.*, in three cases of uterine cancer since then, and two of them were cured. My experience with these remedies in cases

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of cancer involving the mammæ, have not realized the same hopeful expectations, except, perhaps, from the *Senecio.*

Surgical Treatment.—The active surgical means that have been employed by the allopathic school for this disease do not promise much. The application of caustics and the severe manipulation that is required to overcome the strictured condition of the bowel increases rather than diminishes the trouble, and I have no hesitation in pronouncing all these processes not only of no curative value but absolutely injurious. Dr. Helmuth has had some experience with electrolysis, and says it is "the best local application" that can be employed. He continues: "I have known cases so far advanced that the patients were apparently beyond all hope, to be arrested and apparently cured, or certainly the the disease held in *statu quo*, by this method." An opinion so reliable and so carefully stated certainly gives us some hope in the use of this important and valuable agent.

The operation of *excision*, as a *dernier ressort*, recommended by Lisfranc, Schute, Levis, Van Buren, Volkmann, and Helmuth—among them all none occupy a more exalted position than our own representative, so far as the success that has attended his efforts in this direction is concerned—has of late been performed with remarkable success.

The steps of the operation, as described by Dr. Helmuth, are carefully and fully laid down in his *Monograph** on this subject, and certainly the good results attending the operation in his hands hold out to the suffering patient encouragement in the midst of his agony, when all other expedients have failed.

The operation of *colotomy* in the left loin, advocated by some modern surgeons, I disapprove of as an unjustifiable and useless procedure, without hope and without adequate relief.

Polypus of the Rectum.—This disease, although somewhat rare, is nevertheless a subject of considerable interest as connected with the affections of this portion of the intestinal canal. It occurs in two principal forms: 1st. The *soft* or *follicular;* 2d. The *hard* or *fibrous* polypus. The soft or follicular variety is a disease of early life; is situated about an inch above the external

* See Monograph on Excision of the Rectum, to which the reader is referred.

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sphincter, is attached to the mucous membrane of the rectum by a narrow pedicle, and consists of a considerable agglomeration of elongated follicles, having a network of small vessels on its surface furnished with papillæ. It varies in thickness and in length, being from half an inch to two inches in length, and of the size of the little finger in thickness. It is generally single, but there are sometimes two or more. It is of a bright-red color, varies in size from that of a pea to a small strawberry, and is of a soft texture. There is little or no suffering connected with its growth, and attention is only drawn to it by the frequent hæmorrhages that accompany every movement of the bowels, and which are sometimes so copious as to emaciate and weaken the patient. This bleeding at times will be continued while the child is at play, the existence of which should lead to a *close* examination, for if it be attached high up it will immediately recede after the action of the bowels and escape observation. The growth can generally be detected by the introduction of the finger within the rectum. When the pedicle is long enough to permit the protrusion of the polyp it may be seized by a forceps and twisted off. In cases where the pedicle is so short that it will not permit the extrusion of the mass, I have introduced a bivalve anal speculum, seized the tumor and removed it, having taken the precaution of previously having the rectum well cleared with an enema.

The Hard or Fibrous Polyp.—This variety of polypus occurs later in life, and is attached to the mucous membrane of the bowel by one or two distinct pedicles. It is of a reddish-white color, firm in structure, very slightly vascular, and in form resembles a pear. It rarely bleeds, is of a fibro-cellular character, occasions a slight mucous discharge, and protrudes from the anus after motion. When attached high up, little uneasiness is produced by its presence, but when it springs out from the bowel low down near the anus, it is exceedingly apt to protrude through the sphincter during stool and to be caught within its contracting folds, producing continued and severe pain. When lodged within the bowel, a sensation of unrelief is felt, as of an enlargement or feculent lump, which keeps up a continual annoyance to the patient and a constant desire for an evacuation. If

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the polyp is associated with an ulcer within the folds of the sphincter, as sometimes happens, the pain is very much aggravated by contact with the ulcer and the sufferings of the patient greatly increased.

The Villous Polypus.—Mr. Swain has introduced to the profession a rare form of this disease, which he denominates the *villous* tumor, from its resemblance to that structure. It occurs in adults, attains the size of an egg, is extremely vascular, and is composed largely of elongated processes or villi. It produces a great deal of inconvenience, resembling a weight or foreign body in the bowel, and is the cause of periodical and prolonged hæmorrhages, by which the health is seriously impaired. Dr. Rokitansky believes the tumor is of a malignant formation, but this characteristic does not receive the confidence of others.

An exceedingly interesting specimen of this peculiar and rare growth is preserved in the museum of St. George's Hospital, which is thus graphically described by Mr. Swain: "It was situated about three inches from the verge of the anus, in the anterior wall of the rectum, evidently springing from the submucous cellular tissue. It is round in form, circumscribed and prominent, and about the size of an orange. The tufts and processes are remarkably well developed. The tumor so obstructed the cavity of the bowel, that almost complete retention of the fæces resulted, and the gut above was very much distended. The bladder was much pressed upon by the diseased mass. It was imposible to say how long the disease had been growing, but it was not detected until about five years before death, when the occurrence of hæmorrhage and of the symptoms before spoken of, led to its discovery. Several attempts were made to destroy the mass by ligature and other means, but it was not possible to effect more than a partial removal of the more prominent portions—an operation that was performed no less than thirty-three times before his death, and on each occasion with temporary benefit. The patient was *seventy* when he died, and no other disease was found in a careful examination of the body."*

* Path. Soc. Trans., xii., p. 120.

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Treatment.—The treatment of polypus of the rectum will be given with special reference to the two varieties presented and the stages of the disease as shown by their pathological evidences. In the first variety, the soft and follicular, and especially in its earlier development, homœopathic treatment is of decided advantage, and I have employed the following remedies with the most excellent results: *Causticum, Calcarea carb., Conium, Lycopodium, Kali jod., Nitric ac., Phosphorus, Sepia, Staphisagria, Silicea, Thuja, Sulph.*

One or more of the above, selected in accordance with their peculiar fitness to the disease, has produced in my hands curative results, especially when applied in form of enema thrown into the rectum three times daily, the same medicine being given internally once or twice a day.

The surgical treatment is simple, and consists in the application of a polypus forceps to the growth, seizing and twisting it off, or throwing a ligature around the pedicle, returning the tumor within the sphincter and permitting it to slough away. If the tumor has attained a considerable size, it should be drawn downwards as far as possible with the forceps, and a ligature applied to the pedicle, when it may be left to slough away as before. *Electrolysis* has been applied to these growths with excellent results, and the practice has gained much confidence from its superior advantages, and I should recommend its use in tumors of considerable size in lieu of the above-named processes.

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ANAL FISSURE.

By L. H. Willard, M.D., Allegheny City, Pa.

Mr. President, Ladies and Gentlemen: I was appointed by our chairman to write upon anal fissure, as my part of the work selected by this bureau, but, upon examining some of the back numbers of our *Transactions*, found that, in 1873, Dr. Eggert, of Indianapolis, had written a very able paper on the subject, describing the pathology and medicinal treatment in such a manner as to leave me nothing but the surgical treatment, which I now propose to give, and thus avoid unnecessary expense and trouble to our publishing committee.

The great majority of our physicians and surgeons may well say there is but little to be done with anal fissure but operation, and this Dr. Eggert acknowledges, although he relates some cases in which our law of cure was verified; but at the same time it is very questionable if it is right to let our patients suffer so long when a simple operation so speedily relieves. However, when we have constitutional causes to overcome the medicinal treatment must be continued. This will depend on the condition of the patient previous to the appearance of the fissure. If the history of the case shows marked derangement before the formation of the fissure, then internal medication is absolutely necessary; if afterwards, the operation will, in all probability, relieve, as we, by operating, remove the local cause, and hence the cure.

The surgical treatment may be divided into local applications, cutting by the knife, and dilatation.

The treatment by local applications is more applicable to recent fissures which have not become indurated, present a smooth, red streak, and, during defecation, a little blood is passed. In

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these cases we have been very successful by making an application of glycerin and Hydrastis, equal parts, applied by means of a camel's-hair brush, morning and evening. Care must be taken that the parts are first thoroughly cleansed, and the applications made directly to the fissure in its entire length. Sometimes the lotion may be composed of the remedy indicated. Belladonna acts well when applied to a highly inflamed fissure with spasm of the sphincter and congestion of the parts around the rectum. It may be applied either in tincture or mixed with glycerin or lard, in the proportion of ten grains of the extract to the ounce. The ointment is to be used morning and evening.

It often happens that along the course of the fissure there is a spot red and more highly inflamed than the rest. This spot is very irritable and painful. To all such an application of the acid Nitrate of mercury will give great relief. This is recommended instead of the Nitrate of silver, as the latter, in some cases, makes the fissure indurated.

Whatever applications are made or remedies used a persistent and untiring treatment must be pursued, with no stoppage until the patient is cured. In the first place the bowels must be kept open. This may be accomplished by enemas of flaxseed tea, night and morning. I find it a good plan to use an enema of a half pint of the tea at night, before going to bed, and in the morning, before the bowels are moved, another enema of a pint. This will soften the excretion and make the passage less painful.

Before making any local application we must be sure that the parts are clean. The soap that I find most beneficial is juniper-tar soap. It may here be added that it has proved extremely beneficial in cases of eczema and itching of the anus. After the parts are thoroughly washed with this, and then with water to remove the alkali, the fissure is ready for the application, which is made by means of the speculum or the fingers, to dilate the sphincters.

Should the fissure be indurated or hard, or should a small polypus or an overlapping piece of skin fall down into the fissure, local treatment will generally fail. In fact such will be the case very often with the recent variety.

The great objections that patients make to the use of the knife tempt us to try the milder means, which, very often, need to be

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supplemented by the more sure and permanent cure by division of the fissure. The operation of dividing the fissure, originated by Boyer, has been greatly modified. His plan was to cut entirely through the sphincter, and thus secure complete rest of the part while healing. His operation was modified by Mr. Copeland, who, instead of completely dividing the sphincter, merely draws the knife down the centre of the fissure, dividing some fibres of the muscle, which is sufficient to relieve the anal spasm.

Allingham says that the reason division sometimes fails is on account of the fissure not being incised deeply enough. He says it should be cut deep enough to divide some fibres of the sphincter, which insures rest in the part. Another way an imperfect cure is made is by not cutting the external portion sufficiently. In one case that came under my observation last year, on which an unsuccessful operation had been performed, the fissure made a little triangular sore right at the verge of the anus, in consequence of an insufficient division of the external part. It made a little *cul-de-sac*, which was burrowing under the skin. A small incision in the line of the old cut was sufficient to relieve the pent-up matter, and the patient soon recovered.

The method by dilatation I have never tried. Some surgeons speak highly of the plan and claim that most cases can be cured by it. This may be so, but certainly that by division is more sure and not liable to fail if done properly.

Dr. Recamier, to whom is credited the origin of the cure by dilatation, claimed that all cases could be cured by this means. Dr. Dolbeau is also in favor of this method, but says relapses will occur. The operation is performed as follows: The patient being conveniently placed, the two thumbs are introduced into the anus, and the tuberosities of the ischii serving as *points d'appui* for the fingers, they are separated until they come in contact with the internal faces of the tuberosities. A resistance is felt, when suddenly there is a feeling of an internal rupture, and the two thumbs touch the bones.

I will append a report of two cases illustrating two of the methods of treatment spoken of.

Mrs. —— consulted me in regard to her baby, aged nine months, who was constipated, and during every passage, and for

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some time afterward, cried incessantly. On examination found a slight fissure on the left side of the anus, which bled a little on dilating the sphincter. This was, apparently, the cause of the constipation, for the intense pain produced by defecation made the little one resist. The treatment was by means of soap already mentioned, and glycerin and Hydrastis applied to the fissure every morning and evening. Causticum 6th, three doses a day, was given internally. In addition, the injection of flaxseed tea was used, every night and morning. In two weeks the little one was well, and examination showed no trace of the fissure.

Mrs. J., aged thirty-two, about two weeks after confinement complained of pain during defecation and afterward. The pain at first was only during defecation; in the course of two or three days it would come on about fifteen or twenty minutes afterward and last an hour or more. On examination a fissure, one and a half inch in length, was found on the left side of the rectum, producing the most intense pain. An operation was advised, but she strongly objected, and wished me to try medicines and local applications, which was done with no good result. Bell., Nit. acid, Pæonia, and Lyc. were given but did no good. After two weeks of this treatment, the pains were so severe and her constitution evidently breaking down, she consented to the operation, which was performed under the influence of an anæsthetic.

In this case there was found, in addition to the fissure first discovered, another upon the other side of the rectum, which measured about a half inch in length. The large fissure, only, was divided, the incision reaching a few lines above and four lines below at the external part, the division being made from within outward. The sphincters were dilated with the fingers, which can be easily done if the patient is under the anæsthetic. This patient recovered nicely without any pain. A few shreds of oakum were placed in the cut, and these renewed for three days were all the after-treatment. After the first movement of the bowels by means of an enema of flaxseed tea there was no further trouble.

In order to be more explicit in regard to the operation by incision we give that described by Ashton. The patient must rest

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on his side, with his knees drawn up and the buttocks projecting over the edge of a sofa or bed, or he may lean over a table or back of a chair. A straight probe-pointed knife should be used. The forefinger, previously oiled, being introduced into the rectum, the knife must be pressed flat upon it till the point reaches the upper margin of the fissure, when its edge must be turned, and an incision made through the mucous membrane, without extending it through the other structures. Care must be taken, if the fissure is situated either on the anterior or posterior portion of the rectum, that the incision be not extended so deeply as to interfere with the integrity of the sphincter. If the wound is made toward the coccyx it splits the fibres of the sphincter and is difficult to heal; if anteriorly, it is liable to cause incontinence of fæces. If a fold of mucous membrane, or a polypus should lie in the track of the fissure, it must be removed, or it will prevent the healing of the fissure.

In conclusion, it must not be supposed that no treatment is required after the operation. While in a great majority of cases very little after-treatment is necessary, still there are some that require atention, and not until all constitutional symptoms, such as constipation, etc., are subdued and the fissure entirely healed, should we cease attention to the patient.

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ANAL FISTULE.

By L. H. Willard, M.D., Allegheny City, Pa.

It is not my intention to give a lengthy description of this disease, but merely to shape the outline and give the treatment.

For purposes of description we have several varieties, namely, blind external, blind internal, and complete fistules, also the horseshoe fistule, which is a variety produced by the burrowing of pus, and hence its name.

In regard to the causes that produce this troublesome affection numerous ones may be given. Foreign bodies in the rectum, such as fish-bones, or bones of birds, abscess, either from blows on the part or from cold, producing what is termed, at first, blind external fistule, and, finally, the mucous membrane of the bowel giving way, making a complete fistule. Ulcerating hæmorrhoids, on the other hand, producing an abscess, which breaking externally makes also a complete fistule. Other causes, from whatever source, if producing injury to the parts around the anus, are very liable to lead to this affection.

Since the physiologists assert that the veins in this region are not supplied with valves, and the nerve supply to the adipose tissue in the rectal fossa is very limited, we can readily understand why these parts are so difficult to heal. An additional cause is the irritable sphincter, which keeps these parts in motion and so prevents any healing except perhaps the blind external fistule.

The most prominent symptoms are the uneasiness about the anus, pain on defecation, more or less tenesmus at stool, and difficulty in defecation; the digestive organs are deranged, and sometimes with this a costive state of the bowels, the evacuations

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covered with pus or blood. The mind also, in some cases, sympathizes with this affliction, and the patient becomes depressed and miserable; sympathetic pains may be felt in the back and loins, to the bottom of the abdomen, down the legs and to the feet. Thus we have mental symptoms growing out of the affection, which will be very apt to mislead unless physical exploration is made.

The diagnosis of the blind external fistule is easily made. The patient should be on a firm mattress or wooden table and lying on the side. The probe is carefully inserted, to see if there is an entrance to the bowel, when the finger, well oiled, is passed into the rectum, and, no opening being found, we have made one step in the examination. The next will be to use the speculum and see if there be any prominent granulations or ulcerated spots which might be the inner opening. Having detected none, an injection is now thrown into the external opening, composed of milk or some chalk mixture, as proposed by Thomas and Curling, to see if it finds its way into the bowel. Not finding any of the fluid entering the bowel, we may safely pronounce it a case of blind external fistule and prepare to treat it by local applications, injections and rest.

As is generally the case, the patients will wish a trial with medicines or injections. If by medicine, the sinus must always be syringed with lukewarm water. The attempt to cure a fistule of this kind by medicines is very unpromising. In my own experience I have no cures to report, and, judging by our literature on the subject, the evidence of every one seems equally unsatisfactory.

Dr. A. R. Thomas mentions (*Pennsylvania State Society Transactions*, 1874–8) some cases cured by medicines, but thinks cures by that means are exceptional.

A more efficient plan would be injections of water to clean out the sinus and then inject compound Tincture of iodine, which should be thoroughly squeezed out, the orifice sealed with collodion and wool, and keep them in bed for three to five days. Remove the wool the third day, squeeze out the sinus, to see if there is any pus, by introducing the finger into the rectum.

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Should there be more pus, the iodine injection should be repeated.

Nitrate of silver is used, Hydrastis, and Tincture of iron also, but I have had better success by injecting these sinuses with wood-naphtha, which is injected into the sinus and afterwards treated as in the injection with Iodine.

It would be in place here to speak of the prevention of these fistules by early and free incisions, when the abscess, which produces them, is forming. An early incision saves destruction of tissue, and in many casese would obviate the forming of these sinuses. Fluctuation in these abscesses is readily detected by introducing the finger into the rectum and pressing against the affected side when, a prominence being noticed and an incision made, the pus is liberated and the parts begin to heal.

I can bear testimony in three cases where I am sure the patients were saved from having fistules by an early and large incision of abscesses near the anal orifice.

Should we fail to heal the sinus by the measures proposed, the next step in the proceeding will be to make this blind external fistule a complete one, which is done by selecting that portion of the mucous membrane which is thinnest and passing a probe through into the rectum. We have then a complete fistule, the treatment of which will be considered hereafter.

The blind internal fistule is usually the result of some injury or ulceration of the lining membrane of the rectum or abscess in the connective tissue beneath the mucous membrane. They are very often mistaken for hæmorrhoids, and are sometimes caused by an ulcerating hæmorrhoid. The patient complains of a great deal of burning after stool. The fæces are often mixed with pus and blood. One good way to make the diagnosis is to introduce the finger into the rectum and press against the side of the bowel. If any pus has formed most likely a prominence will be seen, and the knife plunged into this prominence will liberate the pus and convert the fistule into a complete one. These means failing, a speculum may be used and reflected light thrown in to illuminate perfectly, when the opening may be found. Allingham proposes to use a probe, bent in the form of a hook, and then to hook this into the internal aperture and bring the point down

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close under the skin, when you cut upon it, thrust it through and complete the operation.

In looking at the situation of the sinus in internal fistule, it may readily be understood that a cure by medicinal means seems impossible, and such is the fact, as borne out by our literature, for no case do we find recorded. Errors are liable to be made and an irritable ulcer mistaken for this affection, but a genuine case of this variety must be made complete, or disastrous results are sure to follow; the pus burrowing in all directions may involve the urethra in the male, the vagina in the female, and thus make such a case as is recorded under number 5. Hence great care is to be exercised in the diagnosis and prompt treatment to make the fistule complete.

I will relate a case that came under my care some years ago. The patient complained a great deal of soreness about the anus, and pain on going to stool. On examination, by introducing my finger into the rectum and pressing against the side, he had the most pain. I could feel with the other finger a hard nodule about one inch from the anus. He positively refused to allow me to operate, which I proposed to do by making it a complete fistule, but insisted on having milder treatment, so he used a warm poultice to the part and took, internally, Bell. 6th. In a day or two he was feeling, to use his own expression, "bully," and laughed at me for trying to get a case. His relief was only temporary. In three weeks I opened a large abscess at the place where I detected the nodule, and he had a hard time of it before he got well. I feel satisfied that if the operation had been performed at the time I first saw him he would have been saved much trouble and suffering.

We have now considered both the blind external and internal fistule: the first amenable to cure in some cases; the second, never.

Failing to cure, we convert both into the complete fistule. One of the most important parts of this subject is the internal opening. The external may be far removed from the anus, but Sir B. Brodie says, the internal opening is always (I think that is his expression) at or near the point of junction of the mucous membrane of the intestine and integument of the anus. Mr.

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Ribes has been given the credit of the investigation showing that the internal opening is never at a greater distance than an inch and a quarter from the anus. He examined seventy-five people who had fistule at the time of their death. In the majority the internal opening was found at the verge of the anus, and in not a single instance did he find it situated at a greater distance from the anal orifice than five or six lines. These results, Ashton says, have been verified since by eminent writers. Allingham says Ribes's observations have been commonly found correct, but not entirely so, and, further, that the reason of the failure to find the opening so often happens is because it is searched for too high up the bowel. Curling, also, says the opening is not invariably at the point as found by Mr. Ribes, but occasionally higher up. In a patient at the Pittsburg Hospital, examined by myself, we found the opening at least two and a half inches up the bowel, and beyond a dense membrane, which had produced a slight stricture. We operated by ligature. So that whilst the observations of Mr. Ribes have done much to simplify the operation and show the true pathology, there are occasional cases where the opening is higher up.

To make sure of the opening, what has been said in regard to the diagnosis of blind external fistule will be applicable here, and prevent the surgeon from running the probe up alongside of the mucous membrane of the bowel, perhaps making an opening higher up than the original one, and thus be the means of many cases of failure.

Having found the internal opening, the time to operate next claims our attention. It has been said by eminent authorities to leave an inflamed fistule alone. Fresh sinuses are apt to form, and failure would be the result. All that can be done is to apply poultices to the part, give medicine to subdue the inflammation, and make incisions to liberate pus and to allow free drainage. Wait until the sinuses have ceased to form, the inflammation has subsided, and the parts are tolerant of handling, and then is the time to operate, if you so decide.

The mode of treatment is first by medicine, as already described; then the operation. We have that by ligature, by pressure, by operation, and by galvano-cautery.

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The remedies that have been recommended are, when the inflammation is erysipelatous, Bell. or Rhus; if there is much sloughing, Silicea; if the parts seem to be unhealthy, Ars. or China, Merc., Sulph., Sil., Hepar sul., Calc. carb., Phos., Caust., Nux may be required, the selection being made by the constitution indications.

The Operation by Ligature.—The material of which the ligature is composed is usually either a pure rubber cord or a silk cord. I have been successful in operating by ligature in several cases. The patients were men who would not leave work, and as the fistules did not give much pain they objected to an operation; so the ligatures were used and did their work in a satisfactory manner. They were all cases in which the fistulous opening was simple and the external orifice near the rectum. The silk cord was used and introduced through the openings and tied over a horn button. First, care was taken that the fistule was thoroughly cleaned and the back part of the sinus irritated with the probe to start up granulations. The ligature was tightened so that it would cut a groove and then only kept tight enough to keep it in place. In this manner some would take two or three weeks in cutting through, but of the limited number in which I have used it all were successful. The healing of the fistulous track kept pace with the ligature. This is the only kind I would be willing to use.

Various devices have been proposed to facilitate the introduction of the ligature. The latest, and probably the best, is one devised by Dr. Helmuth, and illustrated in the *North American Journal of Homœopathy*, vol. xxviii, p. 254. It is intended especially for the elastic ligature, but will serve equally well for the silk. Unless the internal opening is situated very high up the eyed probe will usually be sufficient. Even when the opening is high up, a plan recommended by Dr. Packard, in the Philadelphia *Medical Times*, to which my attention was called by my friend, Dr. Caruthers, will prove both practicable and easy. It is as follows: The probe is introduced through the fistule into the bowel in the usual manner. The silk ligature is then carried into the bowel on the top of the forefinger in the cleft under the free extremity of the nail. When the ligature is thus in the rectum it

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is easy to slip the loop over the probe. The finger being then withdrawn the two extremities of the ligature are twisted tightly together until the probe is firmly grasped by it, and the probe being withdrawn the ligature necessarily follows. It is only necessary to see that the extremity of the probe is bulbous enough to prevent slipping, which is the case with the ordinary pocket-case probes.

The Treatment by Pressure or Dilatation.—The forcible dilatation of the sphincter, as recommended in the treatment of fissure of the anus, has been successfully used. A method that was used in Bellevue Hospital in 1864 was to insert a sponge compress into the anus, the steady, equable, outward pressure gradually dilating the sphincters. Some cases are reported as cured in less than a week.

In the operation for complete fistule, where there is doubt about the length of the sinus, it is best to have the patient under the influence of an anæsthetic so that a free division may be made. The operation is best performed by placing the patient on the side corresponding to the fistule, the bowels, in the meantime, having been thoroughly opened by injection or purgative. The grooved director is now introduced through the sinus into the rectum, and the finger introduced and hooked to the end of the director and its point made to appear at the anus, then a curved bistoury is carried along the groove of the director and the parts are completely divided. If the patient is very muscular a long, probe-pointed bistoury is introduced and the finger placed in the rectum to guide the point of the knife when the handle is depressed and the point made to appear at the anus, the bistoury carried onward dividing the intervening tissue. All sinuses are to be opened and the hardened walls scarified thoroughly with the knife to make the wound heal from the bottom. It was a custom of Mr. Salmon, Allingham says, to make a reverse incision. Thus he would say, when the division of the sphincter had been made, "Now I have a fissure and this is the cure," drawing his knife along the posterior wall of the sinus in the same manner as for anal fissure. His plan has been generally adopted. It makes the wound granulate and hastens the cure. In those cases of long standing, especially where the walls of the sinus are hard and but little dis-

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posed to granulate the latter part of the operation is particularly valuable. If the integuments are badly nourished and tend to drop into the sinus they must be cut off so as to leave no flaps or angles, and any superfluous pieces of tissue must be removed until we have a clean cut allowing free drainage. In some cases there will be more than one external opening far away from the anus, but having only one opening into the bowel; it is not necessary to open up the farthest one. The nearest one is selected and the incision made into the rectum and the other sinuses cleaned with Hydrastis or Condy's fluid, and it readily heals provided the patient's health is good.

In those cases where the sinus runs up along the side of the bowel it used to be considered that the opening must be there also, and hence the incision was made, including, in some cases, considerable connective tissue, and producing hæmorrhage, which is at all times hard to arrest. At the same time the natural opening escaped division. This was in consequence of the opening not being sought for in the right direction, and a complete fistule taken for a blind external one, with a greater division of parts than was necessary, and the original opening not being included in the division failure resulted.

Such authors as M. Ribes, Syme, and Sir B. Brodie, also taught that when a fistule passed some distance up the bowel it was not necessary that it should be divided in its whole extent, and that if the parts between the inner and outer openings be divided the sinus above would probably close and a cure result.

The experience of all the recent authorities does not coincide with this view, but it is found that the wound assumes an unhealthy aspect and a free discharge continues. This was the result in case number three, and so much do I value this point in the operation that I have had it illustrated as one of the most important parts of the operation.

In regard to the dressings in fistula I do not think anything we have excels in value oakum, which being picked fine and well dusted is made into small pledgets and placed in the wound, not to stuff it full but merely to keep the parts open to get granulation from the bottom. It is disinfectant and healing. Cotton-wool is generally used, but any one who has used the oakum

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will discard all other dressings. The oakum may also be used before applying the bandage to keep the parts at rest. A small pad is made of it for this purpose and placed over the anus, and the T bandage applied over it and kept there for two or three days, when it is removed, and if there is no danger of hæmorrhage may then be dispensed with, unless the wound looks unhealthy, when we generally use the wood naphtha to excite healthy granulations.

In regard to the advisability of attempting to cure a fistule in patients predisposed to phthisis, we find that there is not the same reluctance among surgeons to operate as formerly. Those who have had most experience claim that they have never had bad results in this class of cases.

CASE I.—Mr. M——, aged 34, had an abscess near the rectum several years ago. After suffering for several days it broke, and ever since he has had a running sore. It would sometimes heal up and remain closed for two months, when it would again break open and discharge pus, followed by continual oozing. His employment, a railroad engineer, prevented his stopping work for treatment, but he desired an examination made to see if he could be relieved. Examination revealed a complete fistule, the external opening about an inch from the anus, the internal opening being just above the external sphincter. There was considerable induration along the course of the sinus, so much that an operation was advised. This he would not consent to, saying that the fistule had not prevented his working for several years, and he could stand it still longer. He would consent, however, to an operation that would not keep him from work. A ligature was applied, silk cord being used, and tied over a common bone button. He continued his work and would come into the office every third day to have the ligature tightened. At the expiration of two weeks he reported having lost the ligature during defecation. On examination I found that the ligature had cut its way out, a complete cure being the result. This was nine years ago, and no return of the disease has been noticed.

CASE II.—Mr. R——, a clergyman, aged 50, came to the office complaining of pain near the rectum. He had an abscess there about three months before, which was relieved by poulticing,

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breaking, as he said, externally. On examination I found a sinus about an inch from the anus, passing into the rectum just above the external sphincter. I applied a silk ligature, securing it over a button, as he wished to keep at his work and would not consent to a cutting operation. The cord was tightened every third day, and on the tenth day the ligature was missing, it having cut through the same as the preceding case. The cure was complete. Five years have elapsed without any return.

These cases were simple and uncomplicated, the patients strong and robust. No medicines were given.

CASE III.—Major F., U.S. A., came under my care for the treatment of a complete fistule. The external opening was about an inch from the anus on the left side. The internal opening was about an inch above the anal orifice. He had been suffering from intermittent fever, and other evils of camp life, which broke his health. There was some blueness around the external orifice of the sinus, and a thin watery discharge oozed from it. He had great flatulence after eating, and was generally worse during the evening. Liver and spleen slightly enlarged. Bowels rather costive. Began treatment by giving Nux 6th every three hours, which improved his condition remarkably. His bowels moved regularly; appetite improved, and all constitutional symptoms were satisfactory when we operated on the seventh day; the discharge from the sinus being the same as before.

The operation was performed in the usual way by means of the grooved director and bistoury. He rallied nicely from the operation with very little loss of blood. The wound was dressed with lint. On the third day his bowels were moved, and the sinus on examination looked healthy. Dressed as before, and gave Nux for four more days, when he appeared to lose his appetite. Then gave Nux 12th every four hours for two days, but his appetite did not improve, and there was noticed a little discharge of pus, which the looks of the wound did not explain, but on examination high up the cut at the entrance to the bowel a small sinus was found running up along the side of the rectum, about a half inch. This was clipped with a pair of scissors so that the whole sinus was laid open, after which the usual dress-

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ing was applied, and in ten days he was apparently cured. Some six months afterward I heard he had no return.

I relate this case to show in what manner the division of the fistule, according to the method adopted by Ribes and others, may be considered unreliable, merely because it was not thoroughly done.

We may consider, however, that perhaps this patient's broken health contributed to this failure. It may be so, but I cannot help feeling that in persons of broken-down strength it is more important to completely divide the sinus to its full extent than in those of a robust nature.

CASE IV.—Mr. M., æt. 45. Was called to see this patient, who lived some distance out of the city, in the oil regions of Pennsylvania. The history of the case was that two months before he had a chill following some exposure, and afterwards complained of a great deal of pain in defecation. He had a high fever and loss of appetite. His brother, who was with him, thinking it merely the result of cold, gave him a dose of blue mass. This did not relieve him, but the pains increased, and, after waiting three days for him to get better, they sent for the nearest physician, who examined him and pronounced it an abscess, and made a small incision. This relieved him for a time, but in a day his pains were as great as ever. Another opening was made, when the abscess discharged great quantities of pus, and continued to discharge. He was in this condition when I examined him. The abscess was discharging freely; the probe passed through into the rectum about two inches from the anus, and could be passed up along the outside of the bowel about eight inches. The fossa was completely dissected by pus, which seemed to burrow in all directions. He had high fever; temperature 104°; pulse 130; tongue dry; and he was in a semi-comatose condition.

I could see no hope of cure, and gave a prognosis accordingly. He lived three days afterward, and, I was told, died delirious.

In this case it seemed the fault was in delaying to send for help; but, even after the surgeon came, a long free incision might have brought about a different termination, and would have given free vent to the pus, which, instead of discharging exter-

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nally, burrowed up along the side of the bowel, and perhaps reached the pelvic cavity.

CASE V.—Mrs. M., æt. about 30, large and robust, weighing 225 pounds. Eight years ago, after her last confinement, she was troubled with hæmorrhoids. When they became better she noticed after every passage a discharge of pus. Being in the country, and away from her physician, she paid no attention to it until the pain on defecation became unbearable. She suffered extreme pain for two days, when an abscess opened into the vagina. Her physician, after the pain and soreness had subsided, injected the sinus with pure Iodine, which closed it up, but in a few days another opened higher up. The discharge of pus per rectum still continued in varying quantity, also the discharge into the vagina. Sometimes none for a week, then a profuse quantity.

In this manner she allowed it to go on for five years, when an abscess formed and opened about three inches from the anus, discharging at the time a pint of pus. She would not submit to an operation, but placed herself under medical treatment, and persisted in this for one year with no good result.

At this stage the patient came under my care. The above history was given me by her husband. On making an examination there was found an external opening about three inches from the anus, which passed directly into the buttock, two inches toward the vagina, then horizontally into the rectum, about an inch above the anal orifice. She still would not submit to an operation, nor did I press the subject, as it was in warm weather (August), and she was so extremely fleshy. The sinus was opened so as to allow free drainage for the discharge, and an injection of wood naphtha, half water, was thrown into the sinus. This injection has been the means of reducing the discharge, which it did immediately, and closed up the sinus, it remaining closed for about a week, when the old opening into the vagina began to discharge pus, and has been doing so ever since about three years ago. The amount of discharge is trifling at present, and her general health is very much improved.

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SPHINCTERISMUS.

By George A. Hall, M.D., Chicago, Illinois.

This painful and peculiarly distressing affection, known also as irritable sphincter ani, demands attention and thoughtful consideration in the enumeration of the surgical diseases of the alimentary tract.

In my opinion the disease is often confounded with those of the rectum, and so escapes proper recognition and treatment.

As to the anatomy of the parts, we have to remember that the sphincter ani is a voluntary muscle, and is composed of muscular fibres having a distinctive function. The external sphincter is situate around the anus, is elliptical from before to behind, flattened to an inch in breadth opposite the anus, and measures from three to four inches in length from its anterior to its posterior extremity. Its muscular fibres describe concentric arcs, attached at the posterior extremity to the point of the coccyx, and are confounded anteriorly with the bulbo-cavernosi and transversi peronei muscles. The internal sphincter, or sphincter intestinal of Winslow, as it is sometimes called, is regarded as a termination of the circular fibres of the rectum. It is annular, and situate around the inferior extremity of the rectum to the extent of a finger's breadth. These sphincter muscles contract, and close the anus. The circulation is through the inferior hæmorrhoidal artery and the radicals of the hæmorrhoidal and pudic veins. The anus is abundantly supplied with nerve filaments from the pudic and sacral plexus.

The physiological act of the anus is performed in defecation. This is accomplished as follows: By the co-operation of the abdominal muscles and the diaphragm with the muscular walls of

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the rectum, levatores ani, and internal sphincter. In expelling the fecal mass through the outlet of the gut there are two essential acts. The consentaneous constriction of the walls of the rectum and the levator ani, and the simultaneous dilatation of the sphincters. The effort of the first of these acts is to diminish the intestine, both in its calibre and its length, and to force the contents towards the anus. The effort of the second act is the opening of the lower orifice of the bowel for the escape of the evacuations.

Sphincterismus is a spasmodic contraction of the sphincter muscles of the anus, is attended with pain and other concomitant symptoms. The causes are local and remote; local, when the disease exists in the sphincter itself, owing to changes in the arrangement and function of the fibres of the muscle. The disease may be congenital; in some cases the anus is preternaturally small; may arise from the thickening of the mucous membrane of the anus and rectum from venereal or specific taints; may result from irritating, profuse vaginal discharges; may result, and often does, from constipation, and the frequent harsh remedial agents employed to move the bowels, or the applications made to diseases within the rectum by caustics or drug-laden suppositories.

The remote causes are such as, secondarily or by reflex influence, induce disordered action, and finally diseased condition. Thus an irritable sphincter may result from mechanical irritation, complication of hæmorrhoids, coccyodynia, vesical calculus, enlarged prostate, neuralgia of the rectum, loss of the power of co-ordination of the muscles in expelling fæces, fistula in ano, ulcer within the rectum, fissure of the anus, pruritus ani, ascarides, trichiasis of the anus, reflex uterine displacements, and possibly other ailments of the reproductive organs and pelvic viscera.

The symptoms will vary with the gravity and extent of the disease. In most cases there is, first, a sense of discomfort in the parts, attended with temporary itching and burning. These symptoms will cease soon after the bowels have passed the fecal mass, and the parts attract but little attention until pressed upon by a reaccumulation within the rectum. As the disease progresses the pain at stool becomes such that the act of defecation is wilfully neglected, the bowels are left to become costive, the

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fecal mass becomes large and hard, and when passed it is with such difficulty as to excite a spasm of the sphincter. This abuse of the bowels, in turn, becomes a cause which increases and continues the disease. The patient will describe these movements of the bowels as almost unendurable, and even think that the real trouble is that the fecal mass accumulates in such a manner as to be too large for passage through the anus. The pain is variable, but is usually stinging, burning, and of a forcing sensation, as if the parts were being lacerated or torn. In severe cases the spasm will continue almost constantly for one, two, or even three hours after stool, and this pain is greater after than during the act. Patients have been known to deprive themselves of food rather than to suffer the pain at defecation, and even to administer to themselves an anæsthetic while at stool. A sharp lancinating and lacerating pain follows in the train of symptoms after the disease has become chronic.

In this stage the sphincters have become so changed from the normal, as above described, as to form an inelastic, hard, hypertrophied mass, which, to the touch, is like a ring of hard rubber or ivory, of variable thickness and breadth. Any contact from within or without will induce a return of a spasm of the levators, so that the orifice of the anus is often so drawn up as to be scarcely visible.

It has been, until recently, the opinion of authors that this disease of the sphincter was always caused by the presence of a fissured anus, or an ulcer within the rectum, but the fact should be known that irritable sphincter ani does exist independent of any other disease or complications.

We have no doubt but there are many mild cases of sphincterismus, which do not amount to perfect occlusion, but simply a sense of moderate suffering, for months or years, while at stool; and extreme modesty in localizing the pain is apt to mislead the physician in regard to the nature of the trouble, internal piles or uterine deviations being oftener suspected and treated.

As to the Treatment.—In the early stages, if the cause be removed, and the bowels are kept soluble and regular for a long period, and all inflammatory or ulcerated diseases early recognized and treated by the mild methods, the muscles will regain their normal condition.

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I prefer, when surgical methods are necessary, to use forcible dilatation, amounting to temporary paralysis of the parts. I prefer this method to frequent dilatation with bougies, or incising the sphincter.

The operation is as follows: Induce perfect anæsthesia, place the patient upon the left side, flex the thighs upon the body. Introduce the thumb of the right hand through the sphincters, the fingers pressing upon the pubes, then introduce the thumb of the left hand, with the fingers on the lower part of the sacrum; then with a firm, steady pressure, draw the thumbs towards the palms of the hands, until all resistance and power of the sphincter has been overcome, and the parts have been thoroughly dilated by a reintroduction of the fingers of the operator's hand made conical. This will cause, in most instances, some laceration and hæmorrhage. Now place the patient in bed, and if, after a few moments following the forcing of the sphincter, hæmorrhage continues, control it by means of styptic cotton packed within the rectum. This may remain until all danger from hæmorrhage has passed. Then it may be removed, and pledgets of lint soaked in Hamamelis, one-half strength of tincture, smeared with Cosmoline, may be introduced within the rectum, to serve the double purpose of a tampon, and to prevent the escape of the fæces, and prolapsus of rectum, upon which the sphincter may begin to contract. This local dressing is to be changed twice daily, and I also recommend at this stage the liberal use of a cerate, composed of the solid Extract of Rhatany, two drachms; plain Cosmoline, two ounces; to be applied around the anus, and also within the rectum. The inflammation following this operation must be met by the indications present. Usually, Aconite and Belladonna are sufficient. The patient is to be kept on a mild liquid diet, and in a horizontal position for several days. The bowels are to be kept soluble for weeks, even if dependent upon enemas.

It may be urged that this paralyzing of the sphincter may result as a permanent paralysis, and that prolapsus may also result from the harsh treatment. These results, in my experience, have never happened, and, I think, are always traceable, either to an unjustifiable extent of dilatation, or absolute neglect in the subsequent treatment.

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STAPHYLORRAPHY.

BY I. T. TALBOT, M.D., BOSTON.

THIS operation is one of quite recent origin, having been first unsuccessfully performed by Roux in 1817, and its methods greatly improved by various surgeons since that time. Defects in the palate are the result of disease, traumatic causes, and congenital conditions, and they vary in extent from the slightest division and separation of the posterior border of the soft palate, to the almost entire absence of both soft and hard palate, and even of the alveolar process and superior maxillary bone. I do not propose in this paper to discuss the various methods of remedying the extensive loss of bone tissue, which has been accomplished by metallic and other plates, but come at once to the treatment of separation of the soft palate by surgical operation.

Not unfrequently the separation of the parts is so great as to look as though the greater part of the soft palate were wanting, an appearance due in great measure to the muscular contraction of the levator palati, palato-pharyngeus, and palato-glossus muscles, while the whole of the soft palate remains merely divided at the median line or raphé.

The operation consists in simply paring the edges of the two sides, and bringing them together by means of sutures, and thus keeping them in place till union has taken place. Muscular retraction is often so great that this is quite a difficult matter, and in 1844 Fergusson suggested the plan of dividing the muscles of the posterior pillar, which has since greatly added to the success of the operation. In fact I look upon this as one of the most important steps in the operation, and, in its performance, the first thing to be done. It may be done either by passing a knife

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directly through the posterior pillar in a direction diagonal to the median line, or, by drawing the posterior border, or uvular portion, forwards, enter a narrow knife, sharply curved on its side, into the upper side of the posterior pillar, and by a subcutaneous section completely divide the muscles which compose that pillar, and which are the principal means of retraction. I prefer this latter method, since it avoids complete perforation of the palate, and, as sometimes happens, the leaving of lateral fistulæ. It requires a little more care and dexterity in its performance, which the result amply repays. Hæmorrhage is sometimes quite profuse, but can usually be controlled by the application of ice or the ether spray. When this muscular division is fully effected the two retracted sides of the palate approach each other, though it may be necessary to divide also the palato-glossus, in order to fully accomplish this, which may be done by dividing the posterior border of the palate at its outer extremity. The paring of the edges is best done by seizing the uvular end with a long narrow forceps, and putting the edge upon a stretch, enter a thin narrow knife at the anterior point of division of the two sides, and, by a sort of sawing motion, remove a thin slice along the entire edge to the very point of the uvula. The same thing must be done with the other side, leaving a little undivided part on entering the knife, which holds the anterior end while the edge is being pared. This is subsequently divided, and we shall have removed a thin slip from both sides which resembles the letter V. The bleeding having ceased, the sides may best be approximated by means of the wire suture. The great liability of kinking the wire renders it important to have but a single wire, which should be soldered to the eye end of the sharply curved needle. Great care needs now to be taken to fully and evenly pass the needle through the palate at points equidistant on each side. Three, or at most four, of these sutures may be needed. These sutures, having been entered, should be carefully held by an assistant till they are all in, and then tied, beginning with the anterior one and proceeding backwards. This is one of the most important steps in the operation, and must be performed in the most careful manner, so as to fully coaptate the edges without too much tension. For this purpose I have devised

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an instrument consisting of a small steel shank about six inches long, somewhat expanded at the end, with two eyes or perforations about a line apart, through which the two ends of the wire suture are passed. By sliding this up to the parts to be united they are brought together, and a turn of this instrument will effectually secure the suture at such point of tension as may be required. The parts should now be kept as quiet as possible, and milk or liquid diet given. The parts may be protected and the chances of union improved by applying Cosmoline to the surface with a camel's-hair brush. The sutures should be carefully watched, and removed as soon as any tendency to sloughing is apparent. After removal, which should be from the fifth to the tenth day, if any opening is left, it can usually be filled up by touching every second day with solid Nitrate of silver.

A word with regard to the time of operation. When the consciousness of the patient required great self-control on his part the operation could only be done at an advanced age, but with the use of anæsthesia it can be done at any time in life. And it is perhaps better to do it before the voice has acquired the peculiar nasal sound so difficult to overcome.

The complete success which has attended several operations in my hands gives me great confidence in the advisability of the operation.

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REPORT

OF THE

BUREAU OF OPHTHALMOLOGY, OTOLOGY, AND LARYNGOLOGY.

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D. J. McGUIRE, M.D.,	Cincinnati, O.

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DISEASES OF THE EYELIDS.

PTOSIS—BLEPHAROSPASM—SYMBLEPHARON—ANCHYLOBLEPHARON—TRICHIASIS—DISTICHIASIS—ENTROPION—ECTROPION.

By F. Park Lewis, M.D., Buffalo, N. Y.

The diseases to which the eyelids are subject are so numerous, and the phases that they may assume are so varied, that much must be embraced in even a cursory examination of them all. This, coupled with the fact, that in our now extensive ophthalmic literature all of these conditions are discussed elaborately and in detail, will hardly make it a profitable undertaking for me in a paper of this kind to consider facts accessible to every one, and to describe conditions with which all are more or less familiar. I shall not attempt, therefore, to describe in full the various functional disturbances and results of inflammatory action assigned for my consideration, but rather give a brief *résumé* of the chief points of interest in each, with the recent advances in this branch of ophthalmology.

The relation which the ocular appendages bear to the eyeball is so intimate, and their functions so important, that any malposition or distortion which they may undergo occasions most serious annoyance. Improper or deficient innervation, abnormalities in the position of the cilia, in-turning or out-turning of the lid, with the various plastic formations, either of the lids to the globe or to each other, are not alone a disfiguration, but as well a serious impediment to vision. Questions touching the method of their relief must then, from the nature of the subject, be of importance.

All will recollect the general anatomy of the lids, and it will

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not be necessary for me to refer to the relation of the grosser tissues, but a knowledge of some of the finer attachments is necessary that the nature of diseased conditions to which I will hereafter refer may be understood. The orbicular fibres, it will be remembered, are thickest and strongest at the palpebral margin, and throughout are intimately adherent to the integument of the lids. Between the tarsal cartilage, on the other hand, and the muscle is loose connective tissue. Closely attached to the cartilage is a fibrous membrane, the fascia tarso-orbitalis, which is the aponeurosis of the levator muscle of the lid. It should also be remembered that a few fibres of the orbitalis—termed the subtarsal muscle—lie between the free tarsal border and the integument on the edge of the lid. Branches of the third pair of nerves supply the levator palpebrarum, while the orbicularis is controlled by the facial. A very common affection of the lid, either as a special trouble or accompanying other diseased conditions, is that of ptosis. This drooping has been found in some instances to be traceable to arrested development of the levator fibres, but it is rarely a congenital defect. It is usually due either to relative or real insufficiency. The weight of the lid may have become disproportionate to the strength of the muscle. A protracted inflammation, either conjunctival or phlegmonous, may have so thickened the tissues that the muscle can no longer perform its function. The lid may be œdematous, or swollen from trauma, or cicatricial adhesions may impede its movement. The most usual form of ptosis with which we meet is that due to real insufficiency, *i. e.*, paralysis, partial or complete, of the third pair. Treatment must depend largely on the associated conditions. If the conjunctiva be trachomatous this must, if possible, be relieved. In paralytic ptosis faradization has sometimes been beneficial. When all treatment proves unavailing the power of the orbicularis may be diminished by the removal of a portion of its substance. This operation, which consists in the excision of an oval piece of integument, together with the muscular fibres beneath, is fully described in every ophthalmic textbook.

Involuntary contraction of the whole or a portion of the fibres of the orbicularis may occur under various conditions. The

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spasm may be either clonic or tonic. The former, which is the true blepharospasm, has been termed by De Wecker, and not improperly, "palpebral chorea." It often occurs in delicate children soon after they begin to attend school, and overtax the accommodation. This is especially true when any refractive anomaly is present. The spasm may vary from a simple twitching, appearing when one is fatigued, to a closure so complete as to render it dangerous to walk alone on busy streets. Occasionally the whole side of the face is implicated in the spasm. Sometimes the lids are closed so tightly during the spasm that complete narcosis must be employed before the cornea can be examined. A unique form of blepharospasm, considered a sympathetic neurosis, has been described by Donder in the *Kleinsche Monatsblätter für Augenheilkunde,* and is referred to by Schweiger in his recent work. One eye had been lost by iridocyclitis when blepharospasm appeared in the other. The lid was tightly and persistently closed, but entire relief followed the enucleation of the diseased eye. In those cases in which the spasm is reflex the original trouble must receive treatment. Foreign bodies must be removed, inflammatory conditions combated. If in the convulsive form the spasms are very severe, or extend to the face, pressure on or division of the nerve has been recommended. The continuous galvanic current is also used. Forcible dilatation of the lids has sometimes controlled the spasm. Charcot's experience with metalbotherapy would suggest its use in obstinate cases. Among the remedies are: Eserine, Physostigma, Nux vom., Igu, Angustura, Agaricus. The latter is especially valuable in simple twitching of the lid.

Among the frequent results of an extensive destruction of the tissues of the lid we find adhesions, either of the lid to the globe, or the ciliary margins to each other, or both of these conditions combined. The introduction of lime or melted metal in the eye is often followed by symblepharon or anchyloblepharon. The palpebral and adjacent ocular mucous membrane are destroyed and slough away; healing occurs by granulation, and the parts become firmly united. If the injury extend to the frænum it quite frequently occurs that no treatment can avail to prevent adhesions. In smaller burns the insulation of castor oil—if any

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adhesions be broken up as often as they occur—may prevent the union of the raw surfaces. Several surgical measures have been suggested for the relief of symblepharon. When a large portion of the lid has been involved I have employed Teale's method of transplantation. In this operation the lid is carefully dissected away from the eyeball until it moves freely. The apex of the symblepharon is left adherent to the cornea. A conjunctival flap is then taken from the bulbar conjunctiva, the apex being upward and adapted to the raw surface of the globe. A similar flap taken from the outer side of the globe is fitted in the opposing wound in the lid. The loose scleral conjunctiva is then drawn together by sutures. Cold-water dressing is then applied. Very little inflammative reaction is likely to follow. I have made Teale's operation by adapting the healthy mucous tissue to but one raw surface, but in extensive adhesions I believe the operation as originally devised gives better results.

When the injury involves the edges of both lids adhesion of the margin may result. This may be partial or complete. The cicatricial bands are usually thin and membranous, and are often found with symblepharon. After division of the new tissue, which should be done on a grooved director, the edges should be touched with Collodion, or at the outer canthus the mucous membrane can be drawn over the raw surface to prevent new attachments. A very peculiar case has recently come under my notice, in which an extensive phlegmonous inflammation had resulted in cicatricial bands uniting the inner middle portion of the lids with each other, while the whole palpebral border was free. This condition is occasionally congenital, when it is known as epicanthus. I have never known of a case in which it occurred in an uncomplicated form as a result of disease. The patient, a lady, 65 years of age, had suffered with most intense phlegmonous erysipelas of the face. So severe indeed, that for weeks the eyes had been closed by the intensity of the swelling. On her recovery the condition of which I have spoken was found to have obtained. Bilateral bands, which seemed directly continuous with the integument of the nose, extended to the distance of about a centimeter over the canthi. The face had a decided Mongolian appearance. She was very desirous of having the disfiguration re-

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moved, so with the assistance of her physicians, Drs. Brown and Dunick, of Buffalo, Chloroform was administered and a plastic operation performed. The bands, which consisted of dense cicatricial tissue, were divided by a horizontal line extending to the integument of the nose. The triangular pieces above and below were then excised. The integument was dissected loose from the hard neoplastic formation beneath and brought in apposition by sutures. Cold-water dressings were then applied, and very little inflammatory reaction followed. Healing occurred by first union, when the deformity was found to have almost disappeared. As there was still some drawing on the lids a further plastic operation was made for its relief. Triangular incisions were made at the point of attachment on either lid, and the flap given a higher point of attachment, just as in the operation for ectropion. The edges of the wound were brought together by sutures, and cold-water dressings applied as before. The lids could now be moved freely, and the uncomfortable drawing was relieved. There was necessarily some scarring of the skin, but the face had again assumed a more natural expression, and the eyes could be used without annoyance.

Another condition of which I wish to speak, as common as it is annoying, is that of distorted lashes, trichiasis or distichiasis, with its frequent accompaniment entropion. This in-turning may be confined to a few of the cilia or the whole palpebral border may be involved. Sometimes little colorless hairs, scratching over the cornea, may excite considerable irritation, and the closest scrutiny is necessary to discover them. The malposition may be due to chronic eczema of the palpebral border.

Ulcers or abscesses at the roots of the hair-bulbs may give them a wrong direction; indeed any form of blepharitis may suffice to turn the cilia inwards.

The treatment of trichiasis will depend largely on the extent of the tarsal border involved. If a few scattered cilia only are misplaced, repeated evulsion may cause the bulbs eventually to atrophy. The bulbs may be permanently destroyed by passing a needle, dipped in caustic potash, completely to the roots. This will not answer where a considerable portion of the lid is involved, as the baldness presents an unsightly appearance. When a small

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clump of lashes is misplaced the most usual operation is that of excision. An incision is made in the tarsal border, below the distorted lashes and above the openings of the Meibomian glands. The incision should be six or seven millimeters in depth, to include the hair-bulbs, and somewhat longer than the space from which the distorted lashes grow. Two lines are then drawn with the knife till they meet above, forming a triangle; this to be excised, and the edges brought together with sutures.

It has been a quite generally accepted belief that, after inflammatory difficulties, such as trachoma, and those which have been accompanied with much photophobia, that violent contractions of the orbicularis change the curvature of the tarsus, so that not only have we trichiasis, but entropion superadded, and that this condition results the more readily from the diminished resistance of the cartilage in acute inflammatory states, and the resulting atrophic shrinking of the conjunctiva. The principle, then, upon which all of the operations for the relief of trichiasis or entropion, or both combined, are based, is that strong tractive power is necessary to return the lid to its true position. Most of the operations now performed consist in the removal of tissue from the lid substance.

All ophthalmic surgeons are familiar with the disappointments that are apt to follow the most successful operation performed with this object in view. The lids may be so much shortened that they cannot be closed, and still the annoying trichiasis persist. A new deformity is superadded, and relapses are liable to occur.

All of these facts are considered by Dr. F. C. Hotz, of Chicago, who, in a recent article in the *Archives of Ophthalmology*, expresses his belief that the plan upon which all of these procedures is based is incorrect. It is not so much strong traction that is required, but traction applied to the best possible advantage. He demonstrates that a very small force is quite sufficient to raise an inverted lid when properly directed. The upper edge of the tarsal cartilage is the fulcrum point of the lid. If a probe be pressed even very lightly on this point, when the eye is closed, the tarsal border is turned outward. The cartilage, *per se*, Dr. Hotz maintains, is rarely if ever curved, and even decided entro-

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pion is wholly traceable to the action of the orbicular muscular fibres. Following Stellwag in the anatomical arrangement concerning the fixed attachments of the orbicularis, the contraction of its fibres tend to draw them toward the horizontal. A change of position results, and the attachments to the cartilage are loosened, and it is to this integumental displacement that entropion and trichiasis are directly due.

Based on this view is the operation which Hotz offers for its relief. The results claimed for it are little or no deformity of the lid, with complete relief of the distortion, and perfect and free mobility. The entropion, moreover, is not liable to recur. These facts are, it would seem, of sufficient importance to justify a full description of the operation.

The lid clamp is not employed, neither does he use the horn-plate. The bleeding is not usually sufficiently profuse to annoy the operator. The incision is made along the upper margin of the cartilage, and from one commissure to the other. The extremities of the incision usually lie about two millimeters above the canthi, and it reaches its highest point at the middle of the lid. As the cartilage varies in size, a fine longitudinal furrow, occupying about this position, may be taken as a guiding line. The skin is apt to drag, even before the sharpest knife, so the margin of the lid is drawn downward till this line becomes horizontal, and the incision made throughout its extent. The fibres of the orbicularis are then divided, when the cartilage is brought to view. Care must be exercised not to divide the tarso-orbitalis, as protrusion of the orbital tissues might cause considerable annoyance.

With a pair of fine forceps the lower integumentary margin is drawn back, and the muscular layer to the extent of about three millimeters carefully dissected away from canthus to canthus. Four sutures are then introduced; the needle is then inserted through the skin two millimeters from the border of the incision, carried through the aponeurosis just above the junction with the fascia tarso-orbitalis, and out through the upper margin of the skin. The knots are then drawn very tightly, cold-water dressings are applied, and when, after three days, the sutures are removed the wound will be found to have healed by first intention.

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While the principle on which this operation is based seems very reasonable, we find a fuller commendation in the fact that Dr. Hotz had operated on forty-six patients by this method, and in all with results equally satisfactory and permanent. By this plan all cases, he says, are susceptible of relief, and without the deformity that so often follows the most favorable operations after the method of Arlt or Græfe.

On ectropion little that is new or original can be said. The various methods of relief are most fully discussed in all the works on ophthalmic surgery, and to these those who are especially interested are referred.

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STRICTURES OF THE LACHRYMAL PASSAGES.

By J. McGuire, M.D., Detroit, Mich.

The frequency of their occurrence, their annoying character, and disfiguring tendency, through distension of the sac, and extension of the resultant or preceding catarrhal process to other tissues, together with their obstinacy under treatment, makes this a subject at least worthy of careful attention. My regret is that I can add nothing to the therapeutics of this condition, but will at the proper time only emphasize a few points which I realize to be of importance in the treatment. Except the obstruction be at or near the punctum, we will probably find in every case, when it finally presents to the physician, that there is a more or less marked blennorrhœa of the sac, in addition to the epiphora, or weeping, of which the patient complains. So much of the anatomy as may be necessary to call attention to the size, form, and direction of the parts under consideration, seems to me proper. I therefore, at the risk of being considered presumptuous, introduce it.

Of the puncta lachrymalia,—which are situate at the inner extremities of the tarsi,—the lower is the larger and more important.

The canaliculi, which conduct the tears from the puncta to the sac, sometimes (Wecker) unite to form a single duct before entering the sac; at others they enter it singly. This fact may have an important bearing sometimes in the treatment by probes. The canaliculi are less than one millimeter in width. The lachrymal sac occupies the lachrymal fossa, being bounded internally by bone, and externally by skin only. That portion of the conduit which is inclosed in bony walls is called the nasal or lachry-

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mal duct. Its diameter in its middle portion (Metz) is one to two millimeters, and its length one to two centimeters, according to the conformation of face. The shape of the tube also varies in accordance with this latter. The whole tract in a normal state is filled by a capillary column of tears. The stratum of vessels surrounding the duct is sufficient to cause the mucous membrane to project forward, and thus be thrown into folds, a fact worth remembering when we would forcibly introduce the probe.

Clinical History.—Usually the attention of the patient is first attracted to his eye by the weeping or lachrymation, this being the condition which brings him to the oculist. Inquiry will often discover one or more previous attacks of acute dacryocystitis, and ocular inspection may reveal a relaxed and catarrhal state of the palpebral conjunctiva.

Also, as a result of suppuration in the sac, there may be a fistula of some form, the small capillary fistula being easily overlooked and difficult to heal. The conditions giving rise to the epiphora, and requiring for purposes of prognosis and treatment, careful differentiation, are irregularities of the lachrymal puncta and canaliculi, and abnormal states of the sac and nasal duct. Through chronic catarrhal processes the puncta may become displaced, or they may become constricted or occluded, this latter taking place as a result of skin eruptions, of small-pox, ophthalmic herpes, etc., involving the punctum. Such occlusions are generally superficial, consisting only of a thin layer of epithelium, the chief difficulty in this condition being to find the lower punctum, the normal papilla having been obliterated by the skin affections, but when the small facet at the site of the punctum has been found, it may be readily reopened by means of the conical or graduated probe, after which it should be enlarged by slitting to the extent of one or two millimeters. This is best accomplished by means of the Weber knife, which, being introduced into the punctum, is pushed horizontally inward along the canaliculus to the sac; without either raising or lowering the handle of the knife, the punctum will be sufficiently enlarged. This manner of slitting the canaliculus just sufficient for the purpose and no more, I consider to be not undeserving of attention, for whether we consider the passage of the tears through these channels into the

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nose, to be the result of aspiration, or due to pressure and the action of the orbicularis muscle, it is manifestly important that this hydraulic apparatus be disturbed as little as possible. Also for the relief of a *deviating* punctum this slight slitting is quite sufficient. Wecker, on this point, says, "When, as used at one time to be recommended in cases of displacement of the punctum, the canaliculus has been transformed into a groove, extending to the caruncle, the course of the tears is necessarily obstructed, and regurgitation takes place, which, in its effects, is as bad as deficient aspiration."

The epiphora may be due to obstruction or obliteration of the inferior canaliculus. The cause (Wecker) of this obstruction may be the presence of a foreign body, the growth of fungi, or the formation of small calcareous concretions, also as a result of acute dacryocystitis, any of which will give rise to morbid discharge and more or less distension of the canal. The diagnosis may readily be made, either from the freedom of the superior canaliculus, or by passing the probe up to the seat of the obstruction; and as slitting of the canal will be indicated as the speediest if not the only remedy, the character of the obstruction will then be revealed.

Of course, if we are satisfied that only slight constriction exists, the use of the probe without slitting is perfectly practicable, and a cure may be readily effected thereby, and in patients who are very nervous about the use of the knife the former method often is preferable, although the objection to the use of the knife in this condition can usually be evaded by proceeding to the operation without stating to the patient just what you intend to do, thus accomplishing your object before the patient is made aware of it.

The part played by the lachrymal sac, when diseased, in producing constrictions and contractions in the duct and canaliculi may be considerable.

A dacryocystitis may be the result or cause of obstruction in some other portion of the conducting channel, and when such obstruction does exist it is comparatively unimportant in a therapeutic sense. Just what relation it may bear to the acute process in the sac, it is quite as important, in a given case of

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dacryocystitis, to know whether stricture above or below the sac does exist. A little care will enable us ordinarily to establish the diagnosis. For instance, if by pressure upon the sac its contents are readily made to pass both through the duct into the nose, or out through the canaliculus and punctum, the patency of these canals will be demonstrated. When, however, this is not satisfactory the probe must be resorted to.

Dacryocystitis does not fall within the limits of this paper, but in order to establish the differential points in treatment between simple catarrhal inflammation of the sac and that complicated with stricture I must call attention to it for a moment. This simple condition occurs frequently by extension of an inflammatory process begun in the nasal mucous membrane. The catarrhal process once established in the sac it becomes distended, thus constituting the so-called *lachrymal* tumor. The object of treatment at this stage, before the walls, having become thinned, have ruptured, should be the removal of the catarrhal condition of the mucous membrane. This, in many cases, may be done "by re-establishing the column of fluid normally interposed between the nasal cavity and the conjunctival cul-de-sac." "There are (Wecker) two points of capital importance here on which much of the success of treatment depends; one is to realize that we are not called on to remove any obstacles which oppose a definite amount of resistance, such as occlusion or constrictions. Therefore all rough or coarse methods are to be deprecated. The second is to realize that any treatment adopted should disturb the physiological functions of the tear passages as little as possible." The accomplishment of these objects is, I believe, best effected by the slight slitting up of the previously described superior canaliculus, followed by the passage of a Bowman No. 2 or 3 probe daily, for ten days or two weeks. Dilatation of the punctum and canaliculus by the conical probe may, in some cases, answer very well also, but generally the incision is more satisfactory, and when made in this slight but sufficient manner there can be no objection to it. In this condition I would by no means ignore the suitable remedy, but as these cases ordinarily present, we must furnish a point of egress for the matter already accumulated in the sac, or it will break through the external

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wall before we have made any impression with the selected remedy. Lest I be misunderstood, I will state that I am not, in the above, including the *acute* or *suppurative* form of dacryocystitis.

Obstructions of the lachrymal duct are of much more serious import than those above considered, for the reason that the tears pass unobstructed into the sac, where they are arrested. The accumulation here soon leads to distension and irritation, and finally to inflammation of the lining membrane of the sac, the degree of which may not stop short of suppuration.

The complaint made by the patient during the first stage will be of overflow of the tears, which occurs as soon as the canaliculi are filled up. On examination of a case of this kind the surgeon will find a globular swelling below the inner canthus, and on pressure, the sac contents will be readily made to pass out at the puncta, proving the patency of the canal above the sac.

The character of the fluid, which may consist of tears and mucus, of muco-pus or of pus, according to the state of the lining membrane, will assist in the selection of the internal remedy at this time, but owing to the already advanced state of the constriction, it will usually be necessary at once to resort to surgical measures in order to prevent the establishment of fistula.

The treatment of obstructions of the nasal duct, both before and after the formation of fistula, has occupied the minds of many of our most skilful surgeons and writers, as Langenbeck, Scarpa, Arlt, Travers, Hays, Bowman, Weber, E. Williams, Stilling, and others. Many of the early methods were barbarous, and left the patient no better and often worse than they found him. We will not here stop to consider them, but pass to the methods of our own time, which are slitting of a canaliculus and the passage of probes or styles.

The objects of treatment are to remove existing disturbances of nutrition and impediments to conduction. Where this is not practicable the suffering of the patient caused by the disturbed conducting power must be relieved as much as possible, hence the usefulness of such operations as the removal of the lachrymal gland and the destruction of the lachrymal sac. The casual indications are the treatment necessary for an existing ozæna, the

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removal of polypi or other outgrowths from the nose or antrum, the cure of chronic inflammation of the Schneiderian membrane, and of chronic conjunctivitis or trachoma. The remedy chiefly to be thought of for the relief of the obstruction is undoubtedly the slitting up of a canaliculus and subsequent frequent probings. The slitting of the superior canaliculus permits a ready escape of the sac contents upward, but in order that they may pass downward it is necessary that the probe should open up the way, thus also favoring the conditions of nutrition. The slitting is readily effected by means of a Weber knife, and when this instrument is provided with a suitable point, the recommendation to dilate the punctum first by means of the probe is entirely unnecessary.

For the physiological reasons already given, I recommend the slitting of the superior canaliculus, unless some condition of obstruction of the inferior one, as an acute suppuration in the sac, etc., makes it necessary to open this.

The frequency of the probings will of course be influenced by the character of the obstruction and the degree of irritation existing at the time. They may vary from daily to once or twice weekly.

The probes which may be used are either bulb-pointed or straight. The straight probe of Bowman is the one I prefer; they are in six sizes, with smooth, round points, and readily flexible. During the early probings, and while the mucous tissues are still puffy and swollen, great care must be exercised. If the probe does not readily pass a point that has been previously passed, it probably is because a fold of the mucous membrane obstructs, and further attempts to pass the probe should be postponed until another day. Another point to be insisted upon is the use of only the smaller and medium-sized probes, as I believe that all the good which can be accomplished by this plan of treatment is best done by using no probes higher than Nos. 3 and 4 of Bowman.

It will be found by comparison that No. 3 of the Bowman series is as large as the ordinary or average nasal duct at its narrow portion, and therefore any attempt to dilate a stricture beyond the normal size of the part, can only result in irritation

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and perhaps laceration of the tissues, thus ultimately leading through cicatricial formations to further contractions. Besides, we have the clinical experience of such men as Von Arlt, Schweigger, Hirschberg, Stellwag, and Wecker, in favor of the small probes, or against large ones. In my opinion the only circumstance under which the style should be used is where the patient can see the physician only at long intervals, and who cannot be taught to introduce the probe himself, when it may be introduced and left a few days at a time, or perhaps only a few hours. But as the rule, it may be stated that the style when worn continuously only perpetuates the existing irritation or excites additional.

Other measures, adjunct to the probe, are collyria of different kinds, introduced by means of the syringe, or by dropping into the internal angle while the patient is requested to wink, when the action of the orbicularis will cause a sufficient quantity to enter the duct. These collyria may consist of weak solutions of Hydrastis, Calendula, Salicylic acid, and zinc or copper, and, while I rarely use any of them, they are not without value in controlling the discharge where the blennorrhœa is considerable, and by this contributing to the immediate comfort of the patient.

Another agent, which may be assigned to this class, and one which I believe is destined to play a very important part in the treatment of lachrymal constrictions, is Electricity, and on account of the very satisfactory results in the use of the constant current —in the hands of various experimenters—in this class of troubles, as well as its known effects in analogous conditions of the urethra, I have omitted to make mention of the methods for dividing or incising the constricting bands, as I believe the current applied through a properly constructed probe will answer the purpose better.* As the successful treatment of these states often requires that the patient be also relieved of existing catarrhal troubles of the nasal and conjunctival mucous membranes, the internal or constitutional treatment becomes important. For this purpose the number of remedies from which a selection in any given case will have to be made is large, but of those which have the more

* See Transactions of the Homœopathic O. and O. Society, for 1879, article by J. H. Buffum.

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specific action on the conditions directly arising from the disturbance in the duct, we may mention Argent. n., *Aurum*, Calcarea, Calendula, Euphrasia, Hepar s., Merc., Petroleum, Pulsatilla, Silicea, and Sulphur, the indications for which can readily be found on consulting the Materia Medica, or briefly by referring to Allen and Norton's *Ophthalmic Therapeutics*.

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TUMORS AND CONGENITAL MALFORMATIONS OF THE PALPEBRÆ—DISEASES OF THE LACHRYMAL GLAND.

By J. H. Buffum, M.D., Chicago, Ill.

The eyelids and subjacent tissues may be the seat of tumors of various kinds; the only tumors peculiar to the eyelids are those which arise from obstruction of the orifices or ducts of some of their numerous glands; other growths, as a rule, differing but little in their nature or results from those of similar structure appearing upon other portions of the body. Of the tumors affecting the eyelids we have, first, those arising from the cuticle or dermoid structure; second, those of and from the tarsus; and, lastly, those of the conjunctiva. A pure classification cannot, however, be made upon this basis, and in the discussion of the subject I shall confine myself to the simple presentation of the various tumors which may affect the lids, in so far as I have been able to compile the materials at hand upon the topic.

Hordeolum, stye, or furunculus of the lid, is the most common of tumors of the lid, if it can be so classed, it being a tumor only in the primary acceptation of the word. It is a circumscribed inflammation of the integument of the lid, and is often regarded as an inflammation of a hair-follicle, being generally developed as a pimple in the vicinity of a hair-follicle at the margin of the lid. Owing to the extreme elasticity of the subcutaneous tissue, and the readiness with which it becomes infiltrated with serum, the eyelid, especially the upper one, often becomes much swollen and somewhat red in color. It increases in size for several days, and in some cases is accompanied by considerable constitutional disturbance. Resolution may take place, or more frequently suppu-

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ration occurs; in the latter case the tumor points and breaks at the outer edge of the lid.

The swelling of the lid attains such proportions in some cases as to mislead by its general similarity to blennorrhœal conjunctivitis. Examination reveals at once the absence of blennorrhœa of the conjunctiva, and the swelling will be found to be localized, apparent to the touch, and painful at the point of greatest swelling.

Styes do not always appear singly, but, like boils elsewhere, may follow each other in successive crops and are prone to recur. Where such is the case care should be used in examining the cilia, which should be epilated every few days to prevent any of the eyelashes remaining in a sheath which should be occupied by a new one.

The chief importance to be attached to these furuncular inflammations is that the hair-follicles may be destroyed by the contiguous inflammation, or involved in the slough, and leave a permanent gap in the row of cilia.

They are generally the result of some general derangement of the health, and the patient will be found to be suffering from anæmia or some disorder of the digestive or circulatory system. Over-use of eyes in hypermetropes and myopes, and exposure to cold winds and irritation are among the frequent causes. If necessary the stye may be punctured with a small bistoury to hasten the evacuation of its contents.

Among the remedies which are particularly useful in arresting the progress of these painful little tumors and removing the disposition to them are Puls., Staph., Phosph., Hepar, Merc., Graphites, Sulphur, and Thuja. As the treatment must, in the majority of cases, be constitutional, many other remedies are useful in individual cases.

Sebaceous tumors occur most frequently in children, and resemble molluscum in their nature, but attain frequently a much greater size. They occur most often at the upper and outer margin of orbit close to the eyebrow. The skin covering them generally retains its normal appearance, or may become somewhat reddened. The contents are inclosed in a cyst-wall, the posterior portion of which is often thickened and hypertrophied,

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the contained matter consisting of a suetlike sebaceous substance, made up of broken-down epithelial cells, fat-molecules, and hairs. In other cases the tumor is softer and its contents more oily.

If the tumor is small and occasions no inconvenience it may be left undisturbed, but if larger it should be removed at once at an early stage. To prevent return it is well to dissect out the cyst-wall without previous puncture; hence it is well to make a free incision through the skin parallel to the edge of orbit. If the tumor is large it may be necessary to make a crucial incision, but generally one long incision is sufficient. The tumor must be carefully dissected away from the adhesions to the surrounding cellular tissue, and if the cyst-wall breaks it is well to touch the remaining portions with Nitrate of silver. The edges of wound are to be carefully brought together and cold dressing applied.

Molluscum contagiosum, or albuminoid tumor, arises from a diseased condition of the sebaceous glands. The follicle dilated by its own contents is, by reason of a proliferation of the cellular tissue surrounding it, bulged forwards and assumes the appearance of a small rounded tumor with a central depression. It incloses a putty-like mass, composed of epithelium and bodies resembling ruptured starch-granules, an appearance pathognomonic of molluscum. These masses are undoubtedly endowed with infecting properties, and the disease is easily communicated among families, but it seems impossible to produce it by inoculation.

The treatment consists in cutting the tumor completely across by a free incision and squeezing out the contents. If the cyst does not separate at the same time it is necessary to extract it with the forceps.

Milium is a minute white tumor, which often appears upon the eyelids when the skin is thin. Although occurring singly they more frequently appear in groups. They depend upon an occlusion of a sebaceous duct, and may increase in size from irritation. They should be pricked with a cataract needle and the contents of the gland pressed out.

Cystic or *sero-cystic* tumors arise from cystic dilatations of the sudoriparous glands, and are frequently transparent. They may appear on different parts of the eyelids, but their most common

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seat is upon the margin. It may be single or a number may be present. It may stand out from the surface well defined, although yet small, and with very thin walls, or it may be so covered by skin as to scarcely project. Its contents may be serous, glairy, or honey-like, clear or colored.

Treatment.—When the tumor is small a free incision by which the contents are evacuated will suffice; a little suppuration ensues and the cyst is destroyed, or it dries and is exfoliated. The cyst-wall, which is areolar tissue with a few elastic fibres, is too thin and too much connected with surrounding parts to admit of being pulled away. If the cyst is thick the application of some escharotic may be required in addition to the incision.

Acne occasionally occurs on the lids in connection with the same general affection of the face, and requires no special mention here.

Lipoma, or fatty tumors, are infrequent in the eyelids. They may generally be readily recognized by their smooth, circumscribed, somewhat lobulated form, and are firm and elastic to the touch. The progress is, as a rule, very slow, and they can be easily removed by an incision.

Warts may appear upon any portion of the lids, but their most frequent situation is on or near the edges. If pedunculated they may be snipped off with the scissors; or if sessile, may be treated with caustics, Acetic acid, or strangulated. They not unfrequently late in life take on an epitheliomatous character. Calc. carb., Causticum, Thuja, and the Iodide of calcarea have proved useful in the removal of verrucæ in many cases.

Papillomata, or follicular nævi, should be treated as warts.

Nævi, or erectile tumors, are vascular congenital tumors, which frequently have their seat upon the eyelids. They should be operated upon when necessary as soon as possible, as difficulties in their removal often increase with advancing years.

The use of ligatures, galvano-cautery, or electrolysis give the best results in their removal.

Injections of Perchloride of iron are often dangerous from clot passing into the general circulation.

In the removal by strangulation the best method is to pass a harelip pin through healthy tissue on the side, a second pin being

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passed at right angles to the first; behind these pins a strong silk thread is drawn, thus ligating and strangulating the tissues. With this method there is much less danger from hæmorrhage, and of portions being left behind to start up new growths, than when the ligature is passed through the vascular mass.

Cornu, or horns, result from hypertrophied epidermis, and are rare in appearance. They should be cut off or ligatured, so as to deprive them of their papillary and dermal attachments.

Epithelioma is the most frequent of all the malignant growths to which the eyelids are liable. It may present itself under three forms,—the smooth, phagedenic, and papilliform. The smooth variety, which is the most common of all, first shows itself, as a rule, in the vicinity of the commissure and the ciliary margin, under the form of a small patch of induration, composed of raised points, which are sometimes more or less transparent.

The phagedenic variety, which generally settles on tissue some distance from the ciliary border, is characterized by the presence of well-marked nodulations, not unlike, except in color, those of lupus. The nodules disappear, but only to leave deep, funnel-like depressions, which merge one into another.

Lastly, the papilliform epithelioma is neither more nor less than a small cancroidal patch, upon which fungous granulations spring up and bleed at the slightest touch. The diagnosis can only present difficulties in the beginning, where there might arise a question of syphilitic origin. The history of the case, and the length of time that has intervened between the first appearance of the epithelioma as a mere wart and its ulceration, will enable a diagnosis to be made, which will be further corroborated by the fact that in such cases the patients are generally over fifty years of age, cancroid of eyelids being very rare under thirty years of age.

The treatment consists in the employment of remedies which seem to promise a fair prospect of success, as Ars., Apis, Phytolacca, Lycopodium, and Potass. chlor. Failing with these it becomes necessary to remove the growth with the knife when not too extensive. Care should be taken to cut only in absolutely healthy tissue, and reunion of wound obtained, either by bringing

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the skin together or by advancing the flaps, or grafting upon the raw surface.

Angioma.—This affection constitutes a serious deformity, and in certain cases is a source of great annoyance, as it transforms the lids into a swollen, doughy mass, which prevents their motion. It is due to dilatation of the lymphatics, and as an idiopathic affection is rare, depending more frequently upon recurrent attacks of erysipelas or chronic eczema.

Xanthelasma, or xanthoma, is, for the most part, small, single, slightly prominent, yellowish tumors of the skin, occurring most frequently upon the eyelids, and consists of fibrous, fatty tissue, or connective tissue containing fat.

Fibroma is occasionally met with as a small hard tumor of the lids, at times occurring congenitally; is of very slow growth, but sometimes exquisitely painful to touch. A growth of this kind should be removed as soon as possible.

Sarcoma.—The round and spindle-celled sarcoma occasionally spring from the eyelids, but as they differ in no respect from similar growths in other portions of the body it is not necessary to notice them particularly here.

Cylindroma.—Von Græfe described a tumor which is sarcomatous in its nature, and met with upon the eyelids, which, while presenting a sarcomatous structure, is distinguished by the fact of its presenting peculiar club-shaped outgrowths from the capillaries and veins. The tumor is painful if very firmly pressed, but spontaneous pain only occurs periodically. It shows a complete tendency to recur after removal, and is difficult to extirpate completely.

Chalazion, or granuloma of the lids, was long confounded with atheromatous cysts, which are very rare in the skin of this part, and with a cystic dilatation of the Meibomian glands, which singly never constitute a chalazion. Still this pathological change may help to form a granuloma by invading the interior of a tarsal gland, by bringing about the obliteration of its excretory duct, or by merely forming a diverticulum to the gland, and so causing it to assume a cystic development. A granuloma appears by preference upon the external surface of the tarsus, on which it always more or less encroaches; it may, however, primarily

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invade this tissue, as it increases distending it in every direction, and in such a manner as to thin the tarsus, chiefly in the direction of the conjunctiva. Lastly, it may become localized at the orifice of a tarsal gland, in which case it forms a permanent tumor, most marked in the internal edge of the lid. It may be divided into external, internal, and marginal varieties. All three extend down to the basement membrane of the tarsus, and, according to some authors, the giant cells are generated in the epithelium itself of the Meibomian glands.

Whatever produces irritation of the tarsal glands may be a cause of granuloma. Persons predisposed to a hardening of the secretion of the sebaceous glands are very liable to have a similar condition of the Meibomian glands; the subjects of acne are also those in which chalazion appears most frequently. Hyperæmia of lid margins, by inducing congestion about the orifices of the excretory ducts of the Meibomian glands, and thereby interfering with the escape of their contents, may favor the growth of these tumors.

Treatment.—The use of Calc. carb. and Calc. iod., Thuja, Staphisagria, and the mercurials, both internally and externally, have caused absorption in some cases. The majority of patients, however, are unwilling to await the uncertain result of medicinal treatment, and in such cases it is best to remove it, either through the skin when developed towards that side, or through the conjunctiva if developed towards the inner surface. In the former case the lid should be compressed by Snellen's or Desmarre's forceps, and dissected out; in the latter case the lid should be everted, grasped with thumb and index finger or with ring forceps, and the granuloma cleaned out with a curette.

Tumors of Conjunctival Portion of Lid.—Growths and excrescences of all kinds springing from the conjunctiva are decidedly rare, but they have been seen in all parts.

Polypus is the most common, and is a fibro-cellular tumor, in which the gelatinous or serous elements prevail, and covered with epithelium. It looks like a vascular prolongation of the conjunctiva, often with a long delicate pedicle, generally of a rose color, and with irregular surface.

Warts may grow from any portion of the palpebral conjunc-

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tiva, and generally causes a muco-purulent conjunctivitis from the irritation.

Treatment.—Extirpation with a pair of scissors is the ready method of dealing with small polypi or warts, care being taken that the incision is carried through sound conjunctiva. Larger masses require to be carefully dissected off, and whether the base is touched with caustic will depend upon the circumstances of the case.

It is well to bear in mind that any morbid growth which keeps up a chronic irritation may induce epithelial cancer; all tumors, therefore, about the conjunctiva should be removed early.

Other tumors of the conjunctiva have been reported, but not appearing upon that of the lids, do not require mention here.

Congenital Malformations of Lids.—Congenital malformations of the lids are but rarely met with. Among those which have been reported, coloboma and epicanthus are the most common.

Coloboma consists in a congenital cleft of lid, confined to one lid, or may be present in both, or again may be two fissures, which are generally close together and connected by a slight bridge of tissue. It is sometimes associated with cleft palate, harelip, coloboma of iris and choroid, and other forms of arrested development.

To cure this deformity it is necessary to pare the edges of the fissure, and unite by wire sutures extending into cartilage, care being taken to bring the lips of cleft accurately together at margin of lid.

Epicanthus is due to a superabundance of integument between the inner canthi, and passing from nose to eyebrow, overlapping to a greater or less extent the inner canthus. A moderate deformity of this kind is not unfrequently present in infants, and disappears as the child grows older, from the development of the bones of the nose and their increased prominence. If, however, the deformity does not disappear in this way it may be necessary to relieve it by operative interference. To do this it is necessary to excise an elliptical fold of skin from the bridge of the nose, the amount removed depending upon the effect which is desired to be produced. The edges of the wound, after being carefully

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dissected up, are brought into close apposition by sutures or hare-lip pins.

Diseases of Lachrymal Gland.—Inflammation of the lachrymal gland is very rare, and produces more or less swelling at the upper and outer border of the orbit, and external to the orbit. The upper lid is swollen and red, the conjunctiva injected and chemosed. If the swelling is very great the globe of the eye is displaced downward and inward, and the movements of the eye are interfered with when looking upward or downward.

The inflammation is rarely violent, but the touch of the region gives excessive pain. In some cases, where the swelling is considerable, fluctuation may appear, the skin break, and pus escape through the opening; this may close up or remain persistent, as a lachrymal fistula through which the tears may escape.

A chronic condition of inflammation of the gland has been observed in some subjects who have suffered for a long time from conjunctivitis or keratitis with considerable lachrymation.

Treatment.—Acon., Belladonna, Hepar, Merc., Sulph., and Calc. c., as may be indicated. In some cases it may be necessary to apply warm poultices, and give free exit to the pus formed.

In chronic cases, after the removal of the exciting cause, the gland will often return to a normal condition; if not Bell., Iodine, or Mercurius may be useful in allaying the irritation.

Hypertrophy of the gland is produced by slow development and without much pain; the tumor is circumscribed, lobulated, somewhat hard, and may attain considerable size. It interferes with the movements of the eye and of the superior lid.

This hypertrophy results from frequent inflammation, but appears in children and new-born infants.

Treatment.—If inconvenience is caused by the increase in the size of the gland it may be extirpated.

Tumors of the Gland.—Fibroma, sarcoma, kystes, and hydatids have been observed. Cancers, however, are extremely rare.

Dacryops, a tumor analogous to ranula, is caused by ectasia of a gland duct. It appears on erosion of the lid as a bluish, translucent, cystlike tumor, covered only by conjunctiva; it may be emptied by pressure, but soon fills again. The treatment is the same as that for ranula.

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REPORT

OF THE

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A NEW MICROSCOPE STAND.

By J. Edwards Smith, M.D., Cleveland, Ohio.

During the session of the "congress" of microscopists at Indianapolis, in 1878, Mr. John W. Sidle, of Philadelphia, and myself formed ourselves into a committee of *two* for the purpose of devising a new microscope stand.

Mr. Sidle and myself were agreed in our opinions that notwithstanding the recent improvements which of late years had obtained, that there was still room for further effort in the construction of microscopes.

It was then and there proposed, deliberated on, and agreed that we would unite our energies in the endeavor to construct a microscope stand which should combine every possible good quality,—be equal to any and all work,—exhibiting all the latest appliances, and, withal, to combine *really reliable workmanship* at the lowest possible cost, in fact, at figures no higher than those commanded by inferior instruments.

This arrangement contemplated that the author should furnish all the suggestions which his long experience with the microscope might afford, while Mr. Sidle was charged with the mechanical part in the construction of the new stand.

This agreement has been carried out to the letter, and from the date named until August last Mr. Sidle and myself have been in close correspondence, and for the purpose named.

The first stand built under our compact was received by me from Mr. Sidle early in August last, and as a matter of course it got a pretty severe overhauling; suffice it to say that I became so much pleased with our new bantling that I gave it the name of "Acme," and have no hesitancy in recommending this joint production of Mr. Sidle and myself to my friends.

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With this preliminary statement I proceed to give the reader a brief description of our new stand.

The "Acme" with closed tube, when in the vertical position, is about fourteen inches in height, and its weight about five pounds.

The foot is of cast iron, "horseshoe" shaped, and similar to the Hartnack patterns, combining in the smallest compass the necessary weight and accompanying solidity. For real work in the laboratory this form of foot is believed to be superior to all others. For those who prefer the tripod model Mr. Sidle will furnish this form at the same cost, or in finished brass at an additional cost of $3.50.

The entire instrument is supported by a heavy single pillar of solid brass, the lower portion of which passes through the cast-iron foot, the two parts being held firmly together by a clamp screw underneath the foot. By virtue of this arrangement the foot can be detached almost instantly, or by a half turn of the lower clamp. The foot can be reversed on the axis of the pillar, thus insuring the greatest stability when the stand is in the horizontal position. The lower shoulder of the brass pillar passing through the foot is accurately turned and fitted, and when desired the moulding at the part of the brass pillar immediately adjacent to the top of the foot can be divided to degrees for the measurement of angular aperture. My own stand is thus arranged.

Besides those already mentioned other advantages occur from having the foot of the stand removable, some of which may be enumerated as follows:

First. By detaching the base the instrument can easily be carried in the pocket. It is also much easier to *pack*, and occupies much less space in the packing. It can thus be carried from place to place, even in the narrow accommodations afforded by a small valise, the bother of lugging about the usual microscope case being no longer necessary.

Second. Mr. Sidle provides, at a small extra cost, a neat black walnut base *board*, furnished with small lamp fitted with universal movements. This board has also the necessary brass fittings to receive the pillar of the microscope, which can be

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clamped to the board. By this arrangement all that is necessary to convert the instrument into a first-class *hand* microscope is to bring the body to the horizontal position and to adjust the object and the illumination.

With the stand as thus arranged I have repeatedly exhibited objects illustrative of my lectures to the college class of 150 students, the instument being passed from hand to hand throughout the entire class and returned to me, everything remaining in perfect order.

To teachers this feature of the stand will be of value. It will also be found a great convenience at times when the microscope is called on to furnish entertainment in the family circle, and objects can thus be exhibited with great rapidity.

By means of a *strong* trunnion joint the body of the instrument can be inclined at any desired position between the vertical and horizontal, the requisite stability of motion being secured by heavy "cheek blocks." The joint has also compensation for wear.

All the working part of the "Acme" above the base are of solid brass, bright finished and nicely lacquered.

The main body tube is $\frac{5}{16}$ths of an inch in diameter. This tube articulates with the limb by means of heavy "T" guides or angle pieces, thus securing broad bearing surfaces, and also perfect freedom from lateral displacement. Mr. Sidle has put himself to much trouble to perfect this portion of the stand.

The main tube is five inches in length. This is supplemented with a draw tube, which can be drawn out to the standard length of ten inches when desired.

The coarse adjustment is by rack and pinion. The rack is well cut and durable, and the movement of the tube by means of operating the large milled heads is exceedingly smooth and entirely without "lost motion."

The fine adjustment is by a large milled head placed at the rear of the limb and *operating the main tube.* This milled head is $1\frac{1}{4}$ inches in diameter, and is divided into twenty divisions. It acts directly, *i. e.*, without lever, on a micrometer screw cut fifty threads to the inch, each division of the milled head representing $\frac{1}{1000}$th of an inch. The fine adjustment can therefore

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be easily made to answer the purpose of a micrometer for measuring small intervals, or for the measurement of cover glasses, etc. In this adjustment the same security against lateral displacement is provided for by means of the "T" angle pieces, as applied to the rack and pinion movement.

The lower end of the main tube carries a nose-piece fitted with the "society screw." This piece can, however, be detached, so that the broad gauge objectives now in process of construction can be used on this instrument.

It has lately come to the surface that the diameter of the "society screw" is not sufficiently large to meet the requirements of the optician when low powers of the widest apertures are demanded. Mr. Sidle is now making for the author a 1-inch glass having a *diameter* of over one inch, and the "Acme" has been designed to meet such requirements.

The main stage consists of a circular metal plate 3¼ inches in diameter, firmly bolted to the heel of the limb, and in such a manner as to be *isolated from the movements of the sub-stage apparatus.* Four holes are drilled through the main stage plate, and so arranged that the spring clips may be adjusted to hold the object-slide in either a vertical or horizontal position; the spring clips may also be transferred to the under surface of the stage, holding the object-slide in contact therewith, when very oblique illumination is to be employed. The well-hole is of the usual size, and is provided with a standard screw-thread, by means of which the Woodward prism and other accessory pieces can be readily placed in position. The stand is thus fitted for such emergencies as require a fixed and central sub-stage separate from the movements of the mirror. The polariscope is also nicely provided for.

The main stage has also conveniences for centring. Furthermore, a solid plug is furnished, which screws into the well-hole, and forming, when desired, a solid stage. This plug has an "X" engraved thereon for centring purposes.

The sub-stage proper, as well as the concave mirror, are attached to a swinging bar by dovetailed blocks, the slides having compensation for wear. The sub-stage can be centred. It is 1½ inches in diameter, and is fitted to carry any of the accessory

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pieces usually accompanying a first-class outfit. The sub-stage and the mirror both slide with easy friction on the swinging bar.

The swing bar traverses the face of a circle of brass placed at the rear of the stage, the centre of this circle being in the plane of an object placed on the stage. The centre of this circular plate is solid, that is to say, it presents a solid core of about one inch in diameter. Outside of this an annular groove is cut therein, in which swings the heel of the swing bar, the method of attachment of the swing bar to the circular plate giving great solidity as well as firmness in motion. Thus it will be seen that the "swinger" swings *not* on a centre but *around* a centre. This part of the mechanism needs only to be seen to be appreciated.

The mirror is of course removable, and a toy candle-holder is provided to take its place for the measurement of apertures.

A supplemental circular and revolving stage plate is also furnished, which "ships" on and off instantly as may be required, and by virtue of a nice little contrivance of Mr. Sidle's the rotatory movement is very smooth, and nearly as central as would be expected from stands of much higher cost.

When desired Messrs. Sidle and Poalk furnish a mechanical stage, which slips on and off, in place of the rotatory plate above mentioned. This mechanical stage has vertical or horizontal motions to the extent of $\frac{3}{4}$ of an inch; this, however, involves an extra cost of $14.

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PARTICLES AND MOLECULES.

By C. Wesselhœft, M.D., Boston, Mass.

I wish to set myself right about the assertion that the microscope has no bearing on high potencies. The misapprehension arises from the confusion that exists regarding *particles* and *molecules*. Our reports have always carefully separated both subjects. Measurable and definable particles are produced by *grinding* hard insoluble substances in a mortar. Their limits, as both Dr. J. Edwards Smith and I have shown, are easily defined, and fall far below the capacity of the microscope, as each one may see for himself. We desire that all should look and see what goes on before their eyes. *Particles are not molecules;* do not misunderstand us. It requires millions of molecules to make a particle. Molecules are the province of molecular science.

We deal only with triturations, and essentially those made according to the Hahnemannian method. Reduction of particles to $\frac{1}{2500}$ths millimeter does not render each particle soluble; they are microscopically large. We can see and define much smaller particles. Minutest marks on diatoms are exposed for centuries to the action of water; they remain intact as beautiful formations of silica, and are clearly visible, while, if soluble, they would have become invisible long ago.

This bureau may be able to throw much light on the nature of substances to be proved. We have not offered any provings in another bureau of which we are also members. We preferred to investigate substances *to be* proved, to see if, in certain triturations, there was really anything provable, or whether it would be worth the while to prove dilutions of substances too coarse to admit of solubility. Such researches, far from injuring our

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provings, will place them vastly higher when their composition is thoroughly known. Far from prohibiting provings, we desire to aid and improve on our methods of proving.

We are *not* opposed to the Bureau of Materia Medica, but desire to work hand in hand with it. Our question is *not* ended to-day; it will remain open, in or out of the Institute, for years, and I hope will attract many earnest workers. We need them; we are surprised that we stand alone. I hope that all will turn their attention to the subject, to aid and correct us, till all questions are amicably determined.

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REPORT

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THE SPHINCTER TERTIUS, OR SPHINCTER RECTI.

By H. E. Spalding, M.D., Hingham, Mass.

Until a comparatively recent period the power of controlling rectal discharges has been delegated to the internal and external ani muscles. To a great degree this belief would seem to prevail at present, since the various English and American anatomists ignore, in their published works, the existence, or claimed existence, of a third sphincter.

Contrary to the presupposed theory, that the rectum is the reservoir in which gradually accumulate the fæces before an evacuation takes place, careful explorations in the human subject prove that in health the rectum is usually contracted and empty. A flexible probe may be passed into the rectum with no escape of gas until it has penetrated the canal about six inches, when gas or fæces, or both, will at once escape through the tube. The fæces do not ordinarily occupy the rectum until the act of defecation commences. This fact has been proved by frequent examinations of the rectum, made at the moment when moderate inclination to go to stool is felt, finding it empty and contracted. The sigmoid flexure of the colon is the normal reservoir in which accumulates fecal matter, and the sensation that incites an effort to discharge the contents of the bowel is induced by this accumulation of matter being forced into the upper and constricted portion of the rectum.

That this condition always prevails cannot be affirmed. If the fæces are in a liquid state they more readily find their way into the rectum, and, as a result of their irritating presence, we have frequent discharges or diarrhœa. In patients and aged

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people the rectum will frequently be found filled with hardened fæces, their very presence there being an indication of disease, and of a failure of the sphincter recti to act. The other fact, sometimes brought forward as proof against the existence of a third sphincter, that on dead subjects the rectum is frequently found filled with fæces, for like reasons does not avail. Moreover, when we remember that in the moribund condition there is naturally a forcing downwards of the contents of the bowels, so as to often result in the escape of fecal matter, we must expect to find the rectum filled, even had not the previous condition of disease favored it.

Fæces may become impacted in the upper rectum and colon, while the lower rectum remains empty. I was called to take charge of a patient, who had been under the care of another and a worthy physician, for an abdominal tumor. The case was pronounced hopeless, and the treatment only palliative. The intestinal canal was declared to be nearly closed by the impinging tumor. Cathartic medicines had been given, and injections, as ordinarily administered, resorted to, with the result of getting a watery discharge but very little fecal matter, occasionally small scybala. The patient was in constant distress, and opiates had been freely used. I found, occupying the left sacral and lumbar regions, what appeared to be a hard, nodulated, and elongated tumor. I ordered an injection, which brought away only two or three small scybala. A digital examination per anum disclosed the lower portion of the passage empty, but the upper portion thoroughly impacted with what appeared to be fecal matter. This condition, the peculiar contour of the tumor, together with the history of the case, which was long-continued and obstinate constipation, led me to diagnose the tumor to consist of fæces. For nourishment I allowed the patient nothing but such liquids as would add little or nothing to the accumulated mass already obstructing the bowels. Attaching a largest-size gum catheter to the canula of a syringe, by means of a piece of firm rubber tubing, I ordered small injections thrown, at frequent intervals, six or eight inches into the rectum. The injections were well retained, and the unpacking soon began. This process was repeated, at such intervals as the condition of

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the patient would allow, for four days, when, to the great joy of all concerned, the end had been reached, and the tumor, like a phantom, had vanished away.

It has for a long time excited surprise among surgeons, that where severe lesions have occurred or operations been performed, destroying both sphincter ani muscles, the patient so generally escaped the disagreeable misfortune incident to an almost constant involuntary discharge of fecal matter, that he could so well control the escape of flatus and fæces. In rupture of the perinæum, in congenital opening of the rectum into the vaginal canal, in prolapsus ani, with complete loss of power in the sphincter ani muscles, the unfortunate patient blesses his good fortune that he still retains control of his bowels, so that the contents are discharged at regular intervals. Ricord reports a case of congenital opening of the rectum into the vagina, yet the bowels acted regularly; and he adds, that during three years of married life the husband remained in blissful ignorance of this abnormal condition in his wife.

These may be termed the physiological proofs of the existence of a third sphincter. They have been accepted differently by the various anatomists. Faget, observing that the fæces were still under the control of the patient, after the removal of the lower portion of the rectum, believed that a new sphincter must have been developed. Houston believed in the existence of an aggregation of circular muscular fibres at the point where it passes through the pelvic fascia. Others, from these and similar proofs, have accepted the fact that there must be a third sphincter in some portion of the rectal canal.

Contrary to the rule in such matters, the presence of this sphincter is more easily demonstrated, physiologically, in the living subject than, anatomically, in the cadaver. Hyrtl "publicly demonstrated the existence of the fibres of the sphincter tertius taking their origin from the sacrum." Nelaton, Velpeau, and others have likewise demonstrated its existence. Hyrtl gives the following directions for demonstrating its presence: "The rectum should be cut upwards, longitudinally, and stretched upon a board and the several layers carefully dissected off until the muscular layer is reached, when the sphincter tertius will be seen as a broad bundle

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of conglomerated muscular fibres." It is usually located about four inches above the anus, or, in other words, at the point where the rectum passes through the pelvic fascia. This fact shows, among other things, that if injections are expected to produce their best results by reaching the impacted fæces and softening them so that they may escape more easily, they must be thrown at least four or five inches into the rectum. This the ordinary rectal canula or tube does not accomplish. Hence it is my custom, for the want of something better, to order that the vaginal canula be used for adults.

It was once my good fortune to discover this sphincter developed to an abnormal degree. The case was one of congenital imperforate anus. I performed the usual operation, making an opening through the sphincter ani to the depth of nearly an inch before reaching the rectal canal. There then escaped a fair, not large, amount of meconium, and I naturally looked upon the operation as successfnl. I used the ordinary means for keeping the anus open, but to my surprise found that only occasionally a little flatus, and of that very little, but no meconium or other matter escaped. At the end of four days the child died, and I was permitted to hold an autopsy that we might discover the cause of the obstruction. The abdomen was enormously distended. The artificial anus I found still open. Opening the pelvis by separating the pubic bones I carefully examined the rectum. The point of obstruction, about two inches from the anus, I found produced by a band of circular fibres, that so constricted the canal that only an ordinary director could be passed through. It was, doubtless, the third or rectal sphincter augmented in the number of its muscular fibres, and at the same time so shortened and permanently contracted, as nearly to produce a complete occlusion of the canal, as had done its fellows the anal sphincters.

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APPENDIX.

DISCUSSION.

Dr. Owens, of Cincinnati: I desire to present some objections to the paper. In the first place this thing of a sphincter tertius is a new discovery in anatomy. Our old anatomists knew nothing about it. Perhaps they have not made quite as many post-mortem examinations as I have made, or as have been made during recent times, consequently the discovery was not made. But if it were true that there are fibres that correspond to what is known as the sphincter tertius, that are found to be in some degree developed in ordinary cases, even if not found a great many times, and yet found a sufficient number of times to be considered a discovery, then I can see that we have really found something which is of value to the profession. But I contend that no such muscle has been discovered as is described by the term "sphincter tertius." I have never yet found, after making careful dissections, any indications of the sphincter tertius in persons who have died from diseases of the rectum, but that at some time anterior, so far as we can know, there has been inflammation or infiltration into the muscular structure of the rectum. In other words, that this sphincter tertius is a product of infiltration into the muscular structure. This, sir, in my judgment, is a pathological product, and not a normal one. I am aware that some gentlemen have undertaken to make a considerable amount of capital out of it of late years, and I present these remarks as a protest against receiving such a dogma until it is further investigated. I believe that in every case where it has been found to exist—I do not deny its existence in ordinary cases where it has been found to exist—I believe that in such cases it is a product of a pathological state. I well remember one lady from Lexington, Kentucky, who came to Cincinnati to be treated by Professor Pulte for some trouble that she had. She was under this gentleman's care for a considerable time. I may say that it was for a trouble of this character. After the

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administration of the proper remedies, and the dilatation of the parts by mechanical means, the sphincter tertius disappeared. The trouble was readily overcome. And so I think in many cases that this is really the secret; that it is an abnormal, or pathological product, and not a normal state, or healthy condition.

DR. MCCLELLAND: I have just one remark to add. The testimony which has been given has been negative testimony. That can always be adduced on any question. The difficulty of the positive testimony is that there is so little of it. If one anatomist of known ability and integrity gives evidence of the third sphincter, and proves it by actual dissection, is his testimony to be invalidated by the negative testimony of one who does not find it? This question is a very important one for us to determine. The second point is, does the function, the normal function of the rectum, as it is and has been investigated and established, justify the theory and the fact that there is a third sphincter? Now if it is found that there are some means by which the contents of the lower bowel are retained, and only escape by the means of the use of injections, when they prove inefficient, the only means of treatment is the introduction into the lower bowel of a dilator. When this is done, and we find an obstruction in the lower bowel which will justify us in saying that we have discovered this sphincter tertius, ought we not to accept it, notwithstanding some one or more has not found it? That is the point.

DR. HALL, of Chicago: This subject of the third sphincter interests me very much, as my surgical paper happens to be upon diseases of the sphincter. In all of my researches I have never been guilty of finding the third sphincter, as related here by my worthy friend and brother, Dr. McClelland. He has given us some good reasons, and yet I can hardly think that they will hold good in every case, or even in this instance. He seems to think that because one case has been found where the muscle has been developed, or at least muscular tissue is found near the sigmoid flexure, that it is sufficient to establish the fact that there is a third sphincter. I think in many of these cases where it is claimed that a third sphincter has been found, that they are cases of imperfect anus. I know that this has been the case in several instances that have come to my knowledge. It even turns out that these are abnormal conditions. And I think if these cases are investigated that they will turn out to be something of this kind; or it would turn out like the case of a new muscle which was discovered not long since by a learned professor, and which he spent a large amount of time in demonstrating to be his new

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discovery, when at last it was found to be an error in dissecting, and not a new muscle, and that they are deviations from the normal condition of the muscular tissue—the muscular tissue in health differing from what we usually expect to find. The effect of this muscle, or pathological condition, is to prevent the fecal contents escaping down into the lower rectum, that is owing to the mechanism of the rectal canal. We have seen this muscle described by the discoverer of it, who says that sometimes it is hardly discernible. All I have to say in regard to it is that I do not believe, if it did exist, that it would hold the fecal contents. In ordinary conditions the fecal contents rise in the colon above the sigmoid flexure, and only when there is an obstruction there, or owing to a prolapsed condition of the parts, and not owing to the muscular condition, or the existence of a change in the muscular structure, or the presence of such a sphincter. I have thought it my duty to take part in this discussion, and I only make these remarks because my subject includes the diseases of the sphincter ani. I have not been able to find—perhaps I have not been fortunate enough—the sphincter tertius so as to recognize it.

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REPORT

OF THE

BUREAU OF ORGANIZATION, REGISTRATION, AND STATISTICS.

I. T. TALBOT, M.D.,	Boston.
H. M. SMITH, M.D.,	New York.
B. W. JAMES, M.D.,	Philadelphia.
LEWIS SHERMAN, M.D.,	Milwaukee.
P. G. VALENTINE, M.D.,	St. Louis.
T. F. SMITH, M.D.,	New York.
M. T. RUNNELS, M.D.,	Indianapolis.
W. N. GRISWOLD, M.D.,	San Francisco.

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Tabulated Statements, Statistics, and Reports of Medical Organizations, I. T. TALBOT, M.D.

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REPORT

OF THE

BUREAU OF ORGANIZATION, REGISTRATION, AND STATISTICS.

THE following tables and report have been compiled with great care, and though undoubtedly many institutions have been omitted, yet these statistics are presented with the hope that, from year to year, they may be made more complete, and thus exhibit the annual growth and status of homœopathy in this country, better than in any other manner. Let it be one of the duties of each homœopathic physician to see that every institution with which he is connected makes an annual report to the American Institute of Homœopathy.

I. T. TALBOT, M. D., Boston,
H. M. SMITH, M. D., New York,
B. W. JAMES, M. D., Philadelphia,
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M. T. RUNNELS, M. D., Indianapolis,
W. N. GRISWOLD, M. D., San Francisco,

Bureau of Organization, Registration, and Statistics.

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HOMŒOPATHIC MEDICAL SOCIETIES IN THE UNITED STATES.

Name of Society.	State.	When organized.	When incorporated.	Meetings.	Annual Meeting, 1880.	President.	Secretary.	No. of Members.	Admitted last Year.	Died last Year.	Annual Dues.	Publications last year.	Delegates.
NATIONAL SOCIETY.													
American Institute of Homœopathy.		1844	Not	Ann.	Milwaukee, June 15.	T. P. Wilson, M. D., Ann Arbor, Mich.	J. C. Burgher, M. D., Pittsburg, Pa.	839	30	19	$5.00	None.	
SPECIAL, SECTIONAL, OR INTERSTATE SOCIETIES.													
Am. Hom. Ophthal'cal and Otological Soc'y.		1877	Not	Ann.	Milwaukee, June 15.	W. H. Woodyatt, M. D., (Deceased.)	F. Parke Lewis, M. D., Buffalo, N. Y.	40	8	1	3.00	Trans.	
Western Academy of Homœopathy.		1874	Not	Ann.	Minneap'lis, June 9.	Geo. S. Walker, M. D., St. Louis, Mo.	C. H. Goodman, M. D., St. Louis, Mo.	150	24	1	3.00	None.	
STATE SOCIETIES.													
1 California State Hom. Medical Society.	Cal.	1877	1878	Ann.	S. Fran'sco, May.	C. W. Breyfogle, M. D., San Jose, Cal.	Sidney Worth, M. D., San Francisco, Cal.	60	6	1	2.50	None.	G. M. Dixon, M. D.
2 Connecticut Homœop. Medical Society.	Ct.	1851	1864	Ann.	New Haven, May.	W. D. Anderson, M.D., New Haven, Conn.	H. M. Bishop, M. D., Norwich, Conn.	50	4	1	2.00	None.	Geo. F. Foote, M. D., G. H. Wilson, M. D., H. M. Bishop, M. D.
3 Delaware State Hom. Medical Society.	Del.	1874	Not	Quar.	Wilmingt'n, Oct.	C. H. Lawton, M. D., Wilmington, Del.	J. M. Curtis, M. D., Wilmington, Del.	7	0	0	2.00	None.	C. H. Lawton, M. D.
4 Illinois Homœopathic Medical Association.	Ill.	1855	Not	Ann.	Chicago, May 18.	T. C. Duncan, M.D., Chicago, Ill.	E. A. Ballard, M. D., Chicago, Ill.	162	16	3	3.00 Initl.	None.	A. E. Small, M. D., D. S. Smith, M. D., R. Ludlam, M. D., J. S. Mitchell, M. D., T. C. Duncan, M. D., E. A. Ballard, M. D., Julia H. Smith, M. D., H. N. Keener, M. D., L. Pratt, M. D., W. Danforth, M. D.

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5	Indiana Institute of Homœopathy.	Ind.	1857	Not	Ann.	Ind'napolis, May 25.	O. S. Runnels, M. D., Indianapolis, Ind.	B. F. French, M. D., Indianapolis, Ind.	71	26	0	2.00	None.	O. S. Runnels, M. D., H W. Taylor, M. D., W. P. Armstrong, M. D., G. W. Bowen, M. D.
6	Hahnemann Medical Association of Iowa.	Ia.	1870	1877	Ann.	Waterloo, May.	H. P. Britton, M. D., Iowa City, Ia.	E. A. Guilbert, M. D., Dubuque, Iowa.	86	20	0	2.00	"The Annual."	E. A. Guilbert, M. D., G. A. Corning, M. D., H. P. Britton, M. D., A. C. Cowperthwaite, M. D.
7	Homœopathic Med. Soc. of State of Kansas.	Kas.	1869	1871	Ann.	Lawrence, May 5.	J. J. Edie, M. D., Leavenworth, Kan.	J. H. Mosley, M. D., Olathe, Kan.	50	6	1	1.00	None.	W. D. Gentry, M. D., T. J. Patchen, M. D., V. W. Sunderlin, M. D., G. H. T. Johnson, M. D.
8	Maine Homœopathic Medical Society.	Me.	1867	1867	Ann.	Augusta, June 1.	C. M. Foss, M. D., Dexter, Me.	W. F. Shepard, M. D., Bangor, Me.	47	5	0	1.00	None.	C. H. Burr, M. D., G. P. Jefferds, M. D.
9	Maryland Hom. Med. Soc. of Baltimore City.	Md.	1875	1875	Ann.	Baltimore, Oct. 14.	A. A. Rothe, M. D., Frederick, Md.	E C. Price, M. D., Baltimore, Md.	81	9	1	2.00	None.	
10	Massachusetts Homœop. Medical Society.	Ms.	1840	1856	Semi-ann.	Boston, Ap. & Oc. 14.	W. H Lougee, M. D., Lawrence, Mass.	H. A Chase. M. D., Cambridgeport, Mass.	180	19	6	5.00	Trans. Vol. 5.	C. Wesselhoeft, M. D., W. Wesselhoeft, M. D., David Thayer, M. D, H. E. Spaulding, M. D., C. H Farnsworth, M. D., I. T. Talbot, M. D., N. R. Morse, M. D., E. U. Jones, M. D., F. H. Krebs, M. D., J. Heber Smith, M. D.
11	Homœopathic Med. Soc. of State of Michigan.	Mic.	1869	1869	Semi-ann.	Ann Arbor, My&Nv.18.	O. R. Long, M. D., Ionia, Mich.	R. B House, M. D., Tecumseh, Mich.	107	18	2	2.00	None.	R. B. House, M. D., L M. Jones, M. D., W. J. Calvert, M. D., B. F. Bailey, M. D.
12	Minnesota State Hom. Institute	Min.	1867	1867	Ann.	Min'eapolis, June 9.	A. E Higbee, M. D., Minneapolis, Minn.	G. H. Hawes, M. D., Hastings, Minn.	52	11	0	1.00	None.	W. H. Caine, M. D.
13	Missouri Institute of Homœopathy.	Mo.	1877	Not	Ann.	Hannibal, Ju. 2 & 3.	D. T. Abell, M. D., Warrenberg, Mo.	W. D. Foster, M. D., Hannibal, Mo.	40	6	0	2.00	None.	Wm. D. Foster, M. D., H. W. Westover, M. D.
14	Homœopathic Medical Soc. of Nebraska.	Neb.	1873	1874	Ann.	Omaha, May 11.	C. L. Hart, M. D., Omaha, Neb.	O. S. Wood, M. D., Omaha, Neb.	15	0	0	1.00	None.	A. C. Cowperthwaite, M. D., O. S. Wood, M. D.
15	Homœopathic Med. Soc. of New Hampshire.	N.H.	1853	1853	Ann.	Concord, June 16.	T. E. Sanger, M. D., Littleton, N. H.	J. C Moore, M. D., Lake Village, N. H.	50	2	0	1.00	None.	

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STATE SOCIETIES.—(*Continued.*)

Name of Society.	State.	When organized.	When incorporated.	Meetings.	Annual Meetings, 1880.	President.	Secretary.	No. of Members.	Admitted last Year.	Died last Year.	Annual Dues.	Publications last Year.	Delegates.
16 New Jersey State Hom. Medical Society.	N. J.	1860	1870	Semi-ann.	Newark, May 4.	W. J. Andrews, M. D., Newark, N. J.	Wallace McGeorge, Woodbury, N. J.	80	8	0	$1.00	None.	J. E. Winans, M. D.
17 New York State Hom. Medical Society.	N. Y.	1850	1862	Semi-ann.	Albany, Feb. 10.	A. R. Wright, M. D., Buffalo, N. Y.	H. L. Waldo, M. D., West Troy, N. Y.	129 Del. 200 P'm't.	7	9	5.00 Del. 3.00 Pmt.	Trans. 1879.	J. W. Dowling, M. D., A. S. Couch, M. D., W. M. L. Fiske, M. D., A. W. Holden, M. D.
18 Homœopathic Medical Society of Ohio.	O.	1864	1878	Semi-Ann.	Cincinnati, May 18 & 19.	H. M. Logee, M. D., Oxford, Ohio.	H. E. Beebe, M. D., Sidney, Ohio.	200	10	2	2.00	Proceedings 1879.	Wm. Owens, M. D., D. W. Hartshorn, M. D., J. C. Sanders, M. D., N. Schneider, M. D., G. C. McDermott, M. D., S. S. Lungren, M. D.
19 Homœop. Med. Soc. of State of Pennsylvania.	Pa.	1866	Not	Ann.	Easton, Sep. 15 & 16.	J. K. Lee, M. D., Philadelphia, Pa.	Z. T. Miller, M. D., Pittsburg, Pa.	142	7	2	3.00	Trans. '74 to '79.	
20 Rhode Island Homœopathic Society.	R. I.	1850	1850	Quar.	Providence, Jan. 23.	I. W. Sawin, M. D., Providence, R. I.	Geo. B. Peck, M. D., Providence, R. I.	37	2	0	5.00	None.	W. von Gottschalck, M. D., Geo. B. Peck, M. D.
21 Homœopathic Med. Soc. of Tennessee.	Ten.	1875	Not	Ann.	Chat'nooga,	E. H. Price, M. D., Chattanooga, Tenn.	W. C. Dake, M. D., Nashville, Tenn.	32	0	0	1.00	None.	J. P. Dake, M. D.
22 Vermont Homœopathic Medical Society.	Vt.	1854	1858	Semi-ann.	Montpelier, Oct.	H. C. Brigham, M. D., Montpelier, Vt.	C. S. Hoag, M. D., Waterbury, Vt.	65	2	0	1.00	None.	G. E. E. Sparhawk, M. D., C. S. Hoag, M. D., J. H. Jones, M. D.
23 Homœopathic Med. Soc. of State of Wisconsin.	Wis.	1865	1868	Ann.	Milwaukee, June 14.	L. A. Bishop, M. D., Fond du Lac, Wis.	E. F. Storcke, M. D., Milwaukee, Wis.	76	8	0	1.00	None.	L. E. Ober, M. D., Sam. Potter, M. D., Julia Ford, M. D.
							Total.....	1,969	192	28			
						LOCAL SOCIETIES.							
1 San Francisco Homœop. Medical Association.	Cal.	1878	Not	Mth.		H. H. Ingerson, M. D., San Francisco, Cal.	Wallace A. Ely, M. D., San Francisco, Cal.	22	5	0	0	None.	
2 Oakland Homœopathic Medical Society.	"						H. H. Lyons, M. D., Oakland, Cal.						
3 Denver Academy of Hom. Medicine.	Col.	1879	Not	Ann.	Denver, Jan. 6.	A. S. Everett, M. D., Denver, Col.	N. C. Hart, M. D., Denver, Col.	12	0	0	3.00		A. S. Everett, M. D.

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4 Central Illinois Homœopathic Society.	Ill.						A. E. Small, Jr., M. D., Logan, Ill.							
5 Illinois Valley Homœopathic Med. Society.	"						H. N. Keener, M. D., Princeton, Ill.							
6 Rock Island Homœopathic Med. Society.	"	1879	Not	Quar.		P. H. Worley, M. D., Davenport, Ill.	C. B. Kinyon, M. D., Rock Island, Ill.	15	0	0	1.00		C. B. Kinyon, M. D.
7 Military Tract District Hom. Med. Society.	"	1870	Not	Semi-ann	Galesburg.		J. H. Miller, M. D., Abingdon, Ill.						
8 Kankakee & Desplaines Val. Med. Assoc'n.	"		Not	Quar.		J. Antis, M. D., Mazon, Ill.	M. B. Campbell, M. D., Joliet, Ill.	18	0	0	1.00		M. B. Campbell, M. D.
9 Homœopathic Med. Ass. of Wabash Valley.	"	1877	Not			H. L. Obetz, M. D., Paris, Ill.	P. B. Hoyt, M. D., Paris, Ill.	20	5	0			
10 Chicago Acad. of Hom. Physicians & Surg'ns.	"	1873	Not		Chicago.	G. E. Shipman, M. D., Chicago, Ill.	H. C. Evans, M. D., Chicago, Ill.	20	8	1	0	None.	H. C. Evans, M. D.
11 Chicago Women's Hom. Med. Association.	"	1879	Not	Mth.	"	L. G. Bedell, M. D., Chicago, Ill.	C. E. Manning, M. D., Chicago, Ill.	13	3	0	1.00		L. G. Bedell, M. D.
12 Clinical Soc. of Hahn. Hospital of Chicago.	"	1877	Not		"	W. H. Burt, M. D., Chicago, Ill.	E. S. Bailey, M. D., Chicago, Ill.	67	11	0	1.00	"The Clinique."	R. Ludlam, M. D.
13 Marion County Homœopathic Med. Society.	Ind.	1871	1871	Bi-mth.	Ind'nap'lis.	O. S. Runnels, M. D., Indianapolis, Ind	M. T. Runnels, M. D., Indianapolis, Ind.	21	3	1	1.00	None.	O. S. Runnels, M. D.
14 Northern Indiana Hom. Institute.	"	1876	Not	Quar.	Elkhart Cy.	W. A. Whippy, M. D., Goshen, Ind.	W. H. Thomas, M. D., Elkhart, Ind.	16	3	0	1.00	None.	
15 Northeast'n Iowa Hom. Medical Society.	Ia.												
16 Northwestern Academy of Medicine.	"	1876	Not		Omaha, Nb.	W. H. Parsons, M. D., Glenwood, Ia.	W. D. Stillman, M. D., Council Bluffs, Ia.	25	11	0	3.00	None.	P. W. Poulson, M. D.
17 Hardin Co. Society of Homœop. Physicians.	"												
18 Linn Co. Homœopathic Medical Society.	"												
19 Central Homœopathic Association of Iowa.	"						V. M. Law, M. D., Cedar Rapids, Ia.						
20 Baltimore Homœopathic Medical Society.	Md.	1874	Not	Mth.	Baltimore.	M. Brewer, M. D., Baltimore, Md.	Alfred Wanstall, M. D., Baltimore, Md.	22	2	1	1.00		
21 Boston Homœopathic Medical Society.	Ms.	1873	Not	"	Boston, Jan. 13.	A. J. Baker, M. D., Boston, Mass.	M. P. Wheeler, M. D., Boston, Mass.	60	5	1	1.00	None.	C. H. Farnsworth, M. D.
22 Bristol Co. Homœopat'c Medical Society.	"												
23 Essex Co. Homœopathic Medical Society.	"	1872	Not	Semi-ann.		F. A. Warren, M. D., Lowell, Mass.	Sam'l Worcester, M. D. Salem, Mass.	46	8	0	1.00	None.	David Foss, M. D.
24 Middlesex So. Homœop. Medical Society.	"	1876	Not	Mth.	Newton, Jan. 1.	E. P. Scales, M. D., Newton, Mass.	Chas. A. Walker, M. D., Natick, Mass.	18	2	0	1.00	None.	H. L. Chase, M. D.
25 Worcester Co. Homœop. Medical Society.	"	1866	Not	Quar.	Worcester, Nov. 12.	C. L. Kingsbury, M. D., Spencer, Mass.	C. L. Nichols, M. D., Worcester, Mass.	33	10	3	1.00	None.	C. L. Kingsbury, M. D.
26 Western Mass. Homœp. Medical Society.	"	1877	Not	"	Springfield, May 19.	A. Harvey, M. D., North Adams, Mass.	Henry Tucker, M. D., Brattleboro', Vt.	31	9	2	1.00	None.	

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LOCAL SOCIETIES.—(*Continued*)

Name of Society.	State.	When organized.	When incorporated.	Meetings.	Annual Meetings, 1880.	President.	Secretary.	No. of Members.	Admitted last Year.	Died last Year.	Annual Dues.	Publications last Year.	Delegates.
27 Massach'ts Surgical and Gynæcological Soc.	Ms.	1877	Not	Quar.	Boston.	S. M. Cate, M. D., Salem, Mass.	G. H. Payne, M. D., Boston, Mass.	57	18	3	$1.00	Trans.	N. R. Morse, M. D.
28 Dispens'y Ass of Boston Univ. School of Med.	"	1879	Not	Mth.	Boston.	H. C. Clapp, M. D., Boston, Mass.	Alonzo Boothby, M. D., Boston, Mass.	28	28	0		None.	
29 Hahn. Med. Soc. of Barry and Eaton Co.'s, Mich.	Mgn.						E. F. Grant, M. D., Detroit, Mich.						
30 Detroit Institute of Homœopathy.	"												
31 College of Physicians & Surgeons of Mich.	"				Detroit.	W. M. Bailey, M. D., Detroit, Mich.	J. G. Gilchrist, M. D., Detroit, Mich.						D. J. McGuire, M. D.
32 Hahnemann Society and Alumni Association.	"	1876	Not	Wk.	Ann Arbor.	G. A. Tabor, M. D., Ann Arbor.	J. C. Wood, M. D., Ann Arbor.	33	26	0	1.00	None.	
33 Jackson Co. Homœop. Medical Society.	"	1866	Not	Quar	Jackson Cy.	J. B. Tuttle, M. D., Jackson City, Mich.	W. J. Calvert, M. D., Jackson City.	18	1	0	1.00	None.	Jas. F. Brown, M. D.
34 Coll. of Physicians and Surgeons of Mich.	"	1878	1879	Wk.	Detroit.	F. X. Spranger, M. D., Detroit, Mich.	J. G. Gilchrist, M. D., Detroit, Mich.	46	6	0	4.00	None.	
35 Ramsey Co. Homœop. Medical Society.	Min.				St. Paul.								Chester O. Higbee, M. D.
36 Hahnemann Med. Soc. of Hamisfar County.	"												
37 Kansas & Missouri Val. Hom. Medical Assoc'n.	Mo.												W. H. Jenney, M. D.
38 St. Louis Soc. of Hom Physicians & Surg'ns.	"	1877	Not	Mth.	St. Louis.	W. A. Edmunds, M. D., St. Louis, Mo.	W. B. Morgan, M. D., St. Louis, Mo.	36	10	0	2.00	Trans.	P. G. Valentine, M. D.
39 East N. J. Homœopathic Medical Society.	N J.												
40 West Jersey Medical Society.	"	1860	Not	Quar.	Camden, May 19.	M. B. Tuller, M. D., Millville, N. J.	S. H. Quint, M. D., Camden, N. J.	30	4	0	1.00		
41 Homœopathic Medical Society of Camden.	"	1878	Not	Mth.	Camden, April.	M. F. Middleton, M. D., Camden, N. J.	S. H. Quint, M. D., Camden. N. J.	10	1	0	1 00	None.	
42 Albany Homœopathic Medical Society.	N.Y.	1860		Quar.	Albany, Jan. 13.	G. H. Billings, M. D., Cohoes, N. Y.	H. L. Waldo, M. D., West Troy, N. Y.	23	2	0	2.00	None.	
43 Broome Co. Homœop. Medical Society.	"					T. L. Brown. Binghamton, N. Y.							
44 Cayuga Co. Homœop. Medical Society.	"	1859		Quar.									

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45 Cha'ta'q'a & Cattara'g's Co.'s Hom. Med. Soc.	N.Y.	1876	1876	Semi-ann.	Jamestown, June 10.	C. Ormes, M. D., Jamestown, N. Y.	C. P. Alling, M. D., Bradford, Pa.	22	5	1	1.00	None.	
46 Chemung Homœopathic Medical Society.	"	1866		Semi-ann.	Dec. 9.			18					
47 Chenango Homœopathic Medical Society.	"	1871		"	Jan. 13.		J. T. Wallace, M. D., New Berlin.	5					
48 Columbia & Greene Co.'s Hom. Med. Societies.	"	1861		"	Hudson, Oct. 14.	S. J. Phillips, M. D., Catskill, N. Y.	P. W. Mull, M. D., Ghent, N. Y.	16	2	2	1.00		
49 Dutchess Co. Homœop. Medical Society.	"	1861		Quar.	Oct. 7.	John Hornby, M. D., Poughkeepsie, N. Y.	John C Otis, M. D., Poughkeepsie, N. Y.	15					
50 Erie Co. Homœopathic Medical Society.	"	1859	1859	"	Jan. 7.	G. W. Lewis, M. D., Buffalo, N. Y.	D. B. Stumpf, M. D., Buffalo, N. Y.	30	2	0	1.50		L. M. Kenyon, M. D.
51 Homœopathic Med. Soc. of County of Kings.	"	1857	1857	Mth.	Brooklyn, May 11.	E. Hasbrouck, M. D., Brooklyn, N. Y.	W. W. Blackman, M. D., Brooklyn, N. Y.	83	8	3	2.00		P. P. Wells, M. D.
52 Livingston Co. Homœ. Medical Society.	"	1863		Semi-ann.	June 10.	G. R. Traver, M. D., Perry, N. Y.	J. A. West, M. D., Geneseo, N. Y.	11	1	0	1.00	None.	
53 Madison Co. Homœop. Medical Society.	"	1865		"	Cazenovia, June 24.	E. C. Bass, M. D., Cazenovia, N. Y.	J. T. Wallace, M. D., Cazenovia, N. Y.	11					
54 Monroe Co. Homœop. Medical Society.	"	1866		Quar.	Rochester, Jan. 20.	Allen B. Carr, M. D., Rochester, N. Y.	C. B. Sumner, M. D., Rochester, N. Y.	25	6	1	2.00	None.	A. R. Adams, M. D.
55 Montgomery & Fulton Co.'s Hom. Med. Soc.'s.	"	1869					J. G. White, M. D., Amsterdam, N. Y.	8					
56 Niagara & Orleans Co.'s Hom. Med. Societies.	"	1871		Semi-ann.	June 10.	Henry Neville, M. D., Albion, N. Y.	F. A. Bishop, M. D., Medina, N. Y.	23					
57 Homœopathic Med. Soc. of Co. of New York.	"	1857		Mth.	New York, Dec. 11.	W. H. White, M. D., New York.	S. Hasbrouck, M. D., New York, N. Y.	172			1.00		T. F. Smith, M. D.
58 Oneida & Herkimer Co.'s Hom. Med. Society.	"	1857		Semi-ann.	Utica, Oct. 21.	M. O. Terry, M. D., Utica, N. Y.	C. E. Chase, M. D., Utica, N. Y.	20	2	2	1.00		
59 Onondaga Co. Homœop. Medical Society.	"	1863		Mth.	Syracuse, May 4.	J. Young, M. D., Liverpool, N. Y.	C. D. Hale, M. D., Syracuse, N. Y.	30	11	3		100 copies Constitution & By-Laws and Medical Ethics.	
60 Ontario & Yates Co.'s Hom. Med. Societies.	"	1861		Semi-ann.	Can'nd'gua, Oct. 15.	Geo. Q. Noble, M. D., Dundee, N. Y.	G. C. Prichard, M. D., Phelps, N. Y.	14	1	0	1.50	None.	C. T. Mitchell.
61 Orange Co. Homœop. Medical Society.	"	1852		Quar.	Oct. 8.	J. W. Ostrom, M. D.	I. S. Bradner, M. D., Middletown, N. Y.	17					
62 Otsego Co. Homœop. Medical Society.	"	1879		Semi-ann.	June 11.		O. S. Pratt, M. D., Oneonta, N. Y.						
63 Oswego Co. Homœop. Medical Society.	"	1861		"	June 10.	C. W. Radway, M. D., Mexico, N. Y.	G. D. McManus, M. D., Oswego, N. Y.	8					
64 Queens Co. Homœop. Medical Society.	"	1873		Quar.	Oct. 28.	J. A. Beldin, M. D., Jamaica, N. Y.	W. A. Allen, M. D., Flushing, N. Y.	7					
65 Rensselaer Co. Homœ. Medical Society.	"	1859	1859	Ann.	Troy, Oct. 21.	C. H. Carpenter, M. D., Troy, N. Y.	A. R. Green, M. D., Troy, N. Y.	15	3	0	1.00	None.	
66 St. Lawrence Co. Hom. Medical Society.	"	1871		Semi-ann.	June 10.	D. E. Southwick, M. D., Ogdensburg, N. Y.	S. Hoag, M. D., Canton, N. Y.	22					
67 Schuyler Co. Homœop. Medical Society.	"	1872	1872	Quar.	Watkins, July 8.	A. P. Hollett, M. D., Havana, N. Y.	F. W. Adriance, M. D., Watkins, N. Y.	15	1	0	1.00	None.	

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LOCAL SOCIETIES.—(*Continued.*)

Name of Society.	State.	When organized.	When incorporated.	Meetings.	Annual Meetings, 1880.	President.	Secretary.	No. of Members.	Admitted last Year.	Died last Year.	Annual Dues.	Publications last Year.	Delegates.
68 Seneca Homœop. Med. Society.	N.Y.	1872		Semi-ann.	Oct. 7.	O. W. Smith, M. D., Union Springs, N. Y.	R. B. Covert, M. D., Seneca Falls, N. Y.	10					
69 Steuben Co. Homœop. Medical Society.	"	1867		Quar.	May 18.	A. M. Gamman, M. D., Corning, N. Y.	W. E. A. Gorton, M.D., Corning, N. Y.	10					
70 Ulster County Homœop. Medical Society.	"	1865			Kingston, May.	Levi Schoffer, M. D., Kingston, N. Y.	F. W. Ingalls, M. D., Kingston, N. Y.	5	0	0	$1.00	None.	
71 Washington & Warren Co.'s Hom. Med. Soc.	"	1865			Jan. 14.	L. A. Clarke, M. D., Cambridge, N. Y.	A. W. Holden, M. D., Glen's Falls.	15					
72 Wayne Co. Homœop. Medical Society.	"	1862		Semi-ann.	June 3.		M. H. Adams, M. D., Palmyra, N. Y.	11					
73 Westchester & Putnam Co.'s Hom. Med. Soc.	"	1865	1865	"	Yonkers, Jan. 28.	Jos. Hasbrouck, M. D., Dobbs' Ferry, N. Y.	R. O. Phillips, M. D., Yonkers, N. Y.	18	3	0	1.00	None.	
74 Soc. of Northern N. Y.	"	1850		Ann.	July 13.	J. F. Niver, M. D., Cambridge, N. Y.	L. A. Clark, M. D., Cambridge, N. Y.	40	0	0			
75 Southern Tier Homœop. Medical Society.	"	1874	1878	Quar.	Corning, Jan. 20.	B. F. Grant, M. D., Bath, N. Y.	A. P. Hollett, M. D., Havana, N. Y.	30	1	1	1.00	None.	
76 Montgomery Co. Hom. Medical Society.	O.	1860	1870	Semi-ann.	Dayton.	W. Webster, M. D., Dayton, O.	J. K. Webster, M. D., Dayton, O.	40	4	1	0	None.	
77 Lorain Co. Homœop. Medical Society.	"	1865					C. F. Cushing, M. D., Elyria, O.						
78 Cleveland Academy of Medicine and Surgery.	"	1865	1865	Mth.	Cleveland, April 29.	H. F. Biggar, M. D., Cleveland, O.	A. C. Buell, M. D., Cleveland, O.	59	4	0	1.00		D. H. Beckwith, M. D.
79 Homœopathic Med. Soc. of Eastern Ohio.	"	1873	Not	Semi-ann.		H. G. Sherwood, M. D., Warren, O.	D. G. Wilcox, M. D., Akron, O.	30	7	1	0	None.	O. D. Childs, M. D.
80 Cincinnati Homœop. Medical Society.	"	1865	Not	Mth.	Cincinnati.	M. M. Eaton, M. D., Cincinnati, O.	J. P. Gephart, M. D., Cincinnati, O.	35	4	0	1.00	None.	M. M. Eaton, M. D.
81 Dayton City Homœop. Medical Society.	"	1879	Not	"	Dayton.	W. Webster, M. D., Dayton, O.	E. A. Nobles, M. D., Dayton, O.	8	0	0			
82 Homœopathic Med. Soc. of Co. of Philadelphia.	Pa.	1866	Not	Mth.	Phila., April 8.	E. A. Farrington, M.D., Philadelphia, Pa.	Charles Mohr, M. D., Philadelphia, Pa.	36	21	0	1.00		B. W. James, M. D.
83 Homœopathic Society of Germantown.	"	1879	Not	"	Germant'n, Oct.		M. M. Walker, M. D.	7	7	0	0		
84 Homœopathic Society of Northwestern Penn.	"	1878	Not	Quar.			Susan F. Rose, M. D., Meadville, Pa.	14	0	0	1.00	None.	

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85	Hom. Med. Soc. of Chester, Delaware & Montgomery Counties.	Pa.	1858	Not		Phila.	T. Pratt, M. D., Media, Pa.	L. W. Hoopes, M. D., Downington, Pa.	25	3	1	1.00	None.	
86	Allegheny Co. Homœop. Medical Society.	"	1866	Not	Mth.	Pittsburg, Dec. 16.	C. P. Seip, M. D., Pittsburg. Pa.	T. M. Strong, M. D., Allegheny, Pa.	41	4	0	1.00	None.	H. H. Hofmann, M. D.
87	Anatomical Society of Allegheny County.	"	1874	1875	"	Pittsburg.	W. H. Winslow, M. D., Pittsburg, Pa.	W. J. Martin, M. D., 1708 Carson St., Pitts'g.	28	6	0			C. F. Bingamon, M. D.
88	Homœopathic Med. Soc. of Middle Tennessee.	Ten.	1875	Not	"	Nashville.	W. C. Dake, M. D., Nashville, Tenn.	W. M. Dake, M. D., Nashville, Tenn.	10	0	0	0	None.	
89	Homœopathic Med. Soc. of Western Texas.	Tex.						G. E. Routh, M. D., Austin, Tex.						
90	Champlain Valley Hom. Medical Society.	Vt.	1874	Not	Quar.	Middleb'y.	H. W. Hamilton, M. D., Brandon, Vt.	F. W. Halsey, M. D., Middlebury, Vt.	24	3	1	1.00	None.	
91	Hahnemann Med. Soc. of the Old Dominion.	Va.					J. V. Hobson, M. D., Richmond, Va.	J. H. Patten, M. D., Richmond, Va.						
92	Milwaukee Academy of Medicine.	Wis.	1878	Not		Milwaukee.	S. Potter, M. D.	E. F. Storcke, M. D., Milwaukee, Wis.	21	4	0	1.00	Milwa'kee Test Rep.	
								Total.....	1,844	294	29			
							CLUBS.							
1	Hughes Medical Club.	Ms.	1879	Not	Mth.	Boston,		W. L. Jackson, M. D.	15	4	0	3.00		W. L. Jackson, M. D.
2	St. Louis Medical Club.	Mo.			(bi.)	June.								
3	Newark Homœop. Med. Union.	N. J.	1873	Not	Mth.	Newark.		E. J. Howe, M. D., Newark.	25		0	3.00	None.	
4	New Jersey Med. Club.	"	1870	Not	"		J. B. Mandeville, M. D., Newark.	J. Younglove, M. D., Elizabeth.	11	3	0	0	0	
5	Buffalo Medical Club.	N.Y.	1879	Not	"	Buffalo.		F. Parke Lewis, M. D., Buffalo.	14	0	0			
6	New York Clinical Club.	"	1877	Not	Semi-mth.	New York, Nov. 7.		A. T. Hills, M. D., 39 W. 36th St., N. Y.	24	2	1	Ass.	None.	Egbert Guernsey, M. D.
7	Hahnemann Club of Philadelphia.	Pa.	1873	Not	Mth.	Hahnem'n's birthday.	R. J. M. Clatchey, M.D. 908 North 10th Street.	W. H. H. Neville, M.D., Philadelphia, Pa.	11	0	0	0	Hahne-mannian	Monthly.
								Total.....	100	9	1			
							MISCELLANEOUS.							
1	Rhode Island Homœop. Library Association.	R. I.	1877	Not	Quar.	Providence, Oct. 25.	I. W. Sawin, M. D., Providence.	Geo. B. Peck, M. D., Providence.	13			5.00		Geo. B. Peck, M. D.
2	Am. Hom. Publishing Society.	Pa.	1877	1878	Mth.	Phila., Nov. 3.	C. Hering, M. D., 112 N. 12th St., Phila.	C. Mohr, M. D., 55 N. 16th St., Phila.				10.00	Vol. 2 Her	ing's Guiding Symptoms.
3	N. Y. Homœop. Mutual Life Ins. Company.	N.Y.	1868	1868	Ann.	N.Y. City, Jan. 29.	E. M. Kellogg, M. D., 257 Broadway, N. Y.	F. B. Mayhew, Esq., 257 Broadway, N. Y.	11,293 pol'c's	588	20		Statistics, etc.	E. M. Kellogg, M. D.

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HOMŒOPATHIC HOSPITALS IN THE UNITED STATES.

NAME.	Where Located.	State.	When incorporated.	When opened.	Name and address of Secretary or Executive Officer.	No. of Beds.	No. of Pat'nts last year.	Cured.	Relieved.	Not Relieve'd	Died.	Value of Hospital and Grounds.	Am't of Debt.	Invested property.	Sources of Income.	DELEGATES.
1 Home for Inebriates.	Stamford.	Ct.		1873	Geo. F. Foote, M. D., Stamford, Conn.	18	25	20	2	3	0	$60,000	0	0	Patients.	Geo. F. Foote, M. D.
2 Luke's Hospital Homœopathic Department.	Ja'ks'nville.	Fla.		1878	N. R. Stout, M. D., Jacksonville, Fla.	12	6	1	1		4	10,000			Contribut'ns.	N. R. Stout, M. D.
3 Hahnemann Hospital.	Chicago.	Ill.	1855	1870	T. S. Hoyne, M. D., Chicago, Ill.	120	281	178	48	49	8	40,000	$5,000	0	Subscriptions Pat'nts & Don.	Wm. J. Hawkes, M. D.
4 Foundlings' Home.	"	"														Jas. P. Mills, M. D.
5 Illinois State Penitentiary Hospital.	Joliet.	"			M. B. Campbell, M. D., Joliet, Ill.	18	1,143				27	State property.				M. B. Campbell, M. D. (Report for 15 months.)
6 Hahnemann Hospital.	Iowa City.	Ia.														
7 Prot. Orphan Asylum.	New Orl'ns.	La.	1853	1853	Mrs. P. R. Middhamis, New Orleans, La.	16	33				1	$150,000	0	0	Subscriptions & Contr'b't'ns.	E. A. Murphy, M. D.
8 Massachusetts Homœopathic Hospital.	Boston.	Mas.	1855	1871	Miss Ell. Frothingham, Boston, Mass.	40	156	83	53	8	9	100,000	0	$40,000	Fund, Sub'ns, Patients.	C. Wesselhoeft, M. D.
9 Consumptives' Home.	"	"														
10 Temporary Home N. E. Moral Reform Soc'ty.	"	"	1838	1838	Miss M. V. Ball, Boston, Mass.	4	24	24				10,000	5,000	0	Contribut'ns, Patients.	C. E. Hastings, M. D.
11 Homœop. Hospital of Univ. of Michigan.	Ann Arbor.	Mgn		1880	A. R. Wheeler, Ann Arbor, Mich.	30	269				0	State property.	0	State.	Supported by State.	H. C. Allen, M. D.
12 Good Samaritan Hosp'l.	St. Louis.	Mo.	1857	1857	H. A. Wiebusch, St. Louis, Mo.	75	156	101	24	19	12	$30,000	0		Contrib't'ns & Pay'g Pat'nts.	S. B. Parsons, M. D.
13 St. Louis Children's Hospital.	"	"	1879	1879	C. H. Goodman, M. D., St. Louis, Mo.	25	15	12	3		0	4,500	0	0	Subscript'ns.	S. B. Parsons, M. D.
14 Orphan Asylum.	Newark.	N. J.	1843		Mrs. A. F. R. Martin, Newark, N. J.	100	31	31			0				Charity.	
15 Albany Homœopathic Hospital.	Albany.	N.Y.	1872	1872	G. A. Van Allen, Albany, N. Y.	30	81	37	12	11	8	20,000	23,000	$200	City, $3,000 per year, Subscript'ns, Patients.	
16 Buffalo Homœopathic Eye & Ear Infirmary.	Buffalo.	"			H. Baethig, M. D., Buffalo, N. Y.											
17 Ingleside Home Hosp'l.	"	"														
18 Buffalo Homœopathic Hospital.	"	"	1872	1872	H. L. Much, Buffalo, N. Y.	40	58	34	21	1	2	10,000	7,000		Co. All'w'nce, Patients.	
19 Brooklyn Homœopathic Hospital.	Brooklyn.	"	1871	1873	J. R. Cowing, Brooklyn, N. Y.	80	344	181	57	43	26	50,000	0	0	City Appropriations, Patients, Contributions.	

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20 Brooklyn Maternity.	Brooklyn.	N.Y.	1871	1871	Mrs. Geo. Stannard, Brooklyn, N. Y.	43	218	206			12	36, 00	19,000	0	Contribut'ns, Ap'priations,	City Patients.
21 Brooklyn Nursery.	"	"														
22 N. Y. State Homœop. Asyl'm for the Insane.	Middlet'wn.	"	1869	1869	M. D. Stivers, M. D., Middletown. N. Y.	225	283	40	22	35	14	508,675	0	F'rm of 211 acr.	State $8,000, Patients.	S. H. Talcott, M. D.
23 Ward's Island Homœop. Hospital.	New York. (Ward's Is.)	"		1875	A. K. Hills, M. D., New York.	391	3,432	1,516	1,293	51	192	City property.			City Ap'tions.	T. F. Smith, M. D.
24 Hahnemann Hospital.	New York.	"	1875	1875	J. H. Thompson, M. D., New York.	76	145	76	39	4	7	$200,000	0	$45,000	Don's & Fairs.	J. W. Dowling, M. D.
25 New York Ophthalmic Hospital.	"	"	1852	1852	R. C. Root, New York.	35	6,122	4,285	1,224		1	100,000	0	0	R'nt of offices, Patients.	T. F. Allen, M. D.
26 Hosp. of the Protestant Half-Orphan Asyl'm.	"	"														
27 Hosp. of the Five Points House of Industry.	"	"														
28 Cleveland Homœop'thic Hospital.	Cleveland.	O.		1879	H. H. Baxter, M. D., Cleveland, O.	38	144	84	40	6	5	100,000	8,000	0	Patients, Contribut'ns.	H. F. Biggar, M. D.
29 Workhouse Homœop. Hospital.	"	"	1870	1871	W. D. Patterson, Cleveland, O.	40	991	842		115	4					H. F. Biggar, M. D.
30 Protestant Hospital.	Toledo.	"			Mrs. A. E. Scott, Toledo, O.	20	46	25	10		4	5,000	3,000	0	Patients.	
31 St. Vincent's Hospital.	Erie.	Pa.	Not	1873	Rev. Mother Agnes.	30	56	48	3	0	5	10,000	0	0	Contribut'ns.	Edward Cranch, M. D.
32 Convent Benedictine Sisters Infirmary.	"	"	"	1865	Rev. Mother Scholastice Erie, Pa.	10	30	26	4	0	0	0	0	0	"	" " "
33 Homœopathic Hospital of Philadelphia.	Philad'lp'a.	"	1869	1869	D. T. Pratt, Phila., Pa.	30	426	385	17		5	35,000	10,000		R'nts, Int'r'st, Sub'ns, Pat'nts	
34 Pennsylv. Homœopathic Hosp. for Children.	"	"		1877	Miss Helen W. Hinkley.	20	53	24	7	3	4	20,000	0	0	Contribut'ns, Patients.	
35 Children's Homœop't'c Hosp. of Philadelphia.	"	"	1880	1877	J. E. James, Phila., Pa.	28	57	31	12		2	Building leased.	0	1,000	Subscriptions & Donations.	J. E. James, M. D.
36 Pittsburg Homœopathic Hospital.	Pittsburg.	"	1866	1866	Wm. R. Childs, M. D., Pittsburg, Pa.	40	334	296	18	5	15	$50,000	10,000	0	Contribut'ns & Patients.	J. H. McClelland, M. D.
37 Rhode Island Homœop. Hospital.	Providence.	R. I.	1879		(Not yet opened to patients.)											
38 St. Vincent's Foundling Asylum.	Milwaukee.	Wis.		1877	Robert Martin, Milwaukee, Wis.	48										
						1,682	14,959	8,595	2,910	353	367	$1,549,175	$90,000	$86,200		

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HOMŒOPATHIC DISPENSARIES IN THE UNITED STATES.

NAME.	Where Located.	State.	When incorporated.	When op'nd to patients.	Name and Address of Secretary or Executive Officer.	No. treated last year.	No. of prescriptions.	Cost of conducting last year.	Amount of Funds.	Amount of Debt.	REMARKS.	DELEGATES.
1 Pacific Homœopathic Dispensary.	S. Fr'ncisco.	Cal.	1876	1877	Mrs. David Wilder, San Francisco, Cal.	2,953	6,072	$812 91	$1,289 30	0		
2 Hahnemann College Dispensary.	Chicago.	Ill.	1855	1855	Temple S. Hoyne, M. D., Chicago, Ill.	4,560	9,360	450 00	0	0		Geo. A. Hall, M. D.
3 Iowa City Homœop. Dispensary.	Iowa City.	Ia.	1877	1877	A. C. Co'perthwaite, M.D., Iowa City, Ia.	327	682	96 00			Expenses pd. by the State.	A. C. Co'perthwaite, M.D.
4 Hom Free Dispens'ry of Baltimore City.	Baltimore.	Md.	1877	1875	Marbury Brewer, M. D., Baltimore, Md.	4,125	11,951	1,200 00	575 00	0		Alfred Wanstall, M. D.
5 Homœopathic Medical Dispensary.	Boston.	Mas.	1856	1857	I. T. Talbot M. D., Boston, Mass.	1,462	4,252	300 00	20,000 00	0		H. C. Clapp, M. D.
6 College Homœopathic Dispensary.	"	"	1856	1873	I. T. Talbot, M. D., Boston, Mass.	8,557	21,012	800 00		0	Exp. paid partly by Cent'l Dispens'ry, p'rtly by College.	W. L. Jackson, M. D.
7 West End Homœop. Dispensary.	"	"	1856	1875	I. T. Talbot, M. D., Boston, Mass.	1,807	4,832	300 00		0	Supported by C'tral Disp'y.	A. Boothby, M. D.
8 Univer of Michigan, Homœopathic Dept. Dispensary.	Ann Arbor	Mgn	1875	1880	A. R. Wheeler, M D., Ann Arbor, Mich.	367	622				Supported by the State.	T. P. Wilson, M. D.
9 Homœop. Free Dispensary.	Detroit.	"										D. J. McGuire, M. D.
10 Coll Free Dispensary.	St. Louis.	Mo.		1878	Jas. A. Campbell, M. D., St. Louis, Mo.	4.116	9.240				Supported by the College.	S. B. Parsons, M. D.
11 Albany City Homœopathic Dispensary.	Albany.	N.Y.	1860	1869	J. J. Peckham, M. D., Albany, N. Y.	3,268	4,370				Supported by the Hospital.	
12 Brooklyn Homœop. Dispensary.	Brooklyn.	"	1852	1852	S. E. Stiles, M D., Brooklyn, N. Y.	11,477	21,600	1,500 00	0	0	Supported by the City.	
13 Brooklyn E. D. Hom. Dispensary.	"	"	1872	1872	Samuel S. Martin, Esq., Brooklyn, N. Y.	12,000	12 456	802 75	818 32	$4,000 00	$1,000 debt paid this year.	
14 Gates Ave. Homœop. Dispensary.	"	"	1867	1867	Volney Aldridge, Esq., Brooklyn, N. Y.	4,095	5,955	1,450 00	1,250 00	0		
15 New York Homœop. Dispensary.	New York.	"										
16 Northeastern Hom. Dispensary.	"	"										

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17 Western Homœopat'c Dispensary.	New York.	N.Y.	1868			8,196	17,113					
18 Tompkins Sq. Hom. Dispensary.	"	"		1874	Edward P. Orvel, Esq., New York, N. Y.	12,474	33,876	1,042 55	0	2,528 83	Formerly br'nch of Bond Street Hom. Disp'y.	J. P. Ermantraut, M.D.
19 New York Homœop. College Dispensary.	"	"	1866	1867	J. W. Dowling, M. D., New York, N. Y.	10,000	27,000	1,000 00	0	0	Supported by the College.	J. W. Dowling, M.D.
20 New York College for Women Dispens'ry.	"	"										S. Lilienthal, M.D.
21 Cincinnati Free Hom. Dispensary.	Cincinnati.	O.	1867	1867	C. A. Quirell, M. D., Cincinnati, O.	3,973	14,832	93 00	Valuable leasehold.	0	Supported by the College.	G. C. McDermott, M.D.
22 Free Dispensary for Women & Children.	"	"	1879	Not	Martha M. Howells, M.D., Cincinnati, O.	794	6,009	120 00	0	0	Supported by contributions.	Wm. Owens, M. D.
23 Good Samaritan Dispensary.	Cleveland.	"		1865	J. Edwards Smith, M. D., Cleveland. O.	1,949	6,307				Supported by the College.	J Edwards Smith, M. D.
24 Women's & Children's Medical & Surgical Dispensary.	"	"	1878	1878	Martha M. Stone, Cleveland, O.	1,260	5,040	366 10	$6 20	0	Supported by contributions.	Myra K. Merrick, M. D.
25 Hom. Hosp Dispensary of Philadelphia.	Phil'd'lphia.	Pa.	1874		D. T. Pratt, Esq., Philadelphia, Pa.	6,461	12,300		0	0	Supported by the Hospital.	A. R. Thomas, M. D.
26 Children's Homœop. Hosp. of Philadelphia Dispensary.	"	"	1877	1877	J. E. James, M. D., Philadelphia, Pa.	3,574	13,711		0	0	Supported by the Hospital.	J. E. James, M.D.
27 Pennsylvania Homœopathic Hospital for Children Dispens'y.	"	"	1877	1877	Miss Helen W. Hinckley, Philadelphia, Pa.	1,207	7,194		0	0	Supported by the Hospital.	
28 Pittsburg Homœop. Hosp. Dispensary.	"	"	1866	1866	Wm. R. Childs, M. D., Pittsburg. Pa.	7,162	14,822				Supported by the Hospital.	J. H. McClelland, M.D.
29 Rhode Island Homœopathic Dispensary.	Providence.	R. I.		1874	Geo. B. Peck, M. D., Providence, R. I.	1,400	2,164	305 87	0	90 87	C'ducted by the State Society.	Geo. B. Peck, M.D.
						117,564	272,772	$10,639 18	$23,938 82	$6,619 70		

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HOMŒOPATHIC MEDICAL COLLEGES IN THE UNITED STATES.

Name of College or Medical School.	Where Located.	When incorporated.	When students first admitted.	Name and Address of Dean.	Lth of each y'rly course and time it commences.	No. of courses req'r'd before graduation	No. of students in past year.	No. of gradu'tes at last Com.	No. of Alumni.	No. of Faculty.	No. of Prof'rs.	No. of Lect'rs.	Estimated value of College Property.	Amount of Endowments.	Am't of Debt.	Am't of Income.	Delegates.
1 Hahnemann Medical Coll. and Hospital.	Chicago, Ill.	1855	1859	R. Ludlam, M. D., 256 Wabash Ave., Chicago, Ill.	31 wks. Oct. 1.	2	253	87	650	11	8	3	$50,000	None.	$18,000	$11,000	A. E. Small, M. D., G. A. Hall, M. D.
2 Chicago Homœopath'c College.	Chicago, Ill.	1876	1876	J. S. Mitchell, M. D., 2432 Michigan Ave., Chicago, Ill.	6 m'nths. Oct. 1.	2	80	20	91	18	13	5	Rents Build'g.	Two Schol-'rsh'ps	None.	4,000	J. S. Mitchell, M. D., J. H. Buffum, M. D.
3 Iowa University Hom. Department.	Iowa City, Ia.		1878	A. C. Co'perthwalte, M. D., Iowa City, Iowa.	5 m'nths. 1st Wed. in Oct.	2	47	9	13	4	3	5	$10,000		None.		A. C. Co'perthwalte, M. D., W. H. Dickinson, M. D.
4 Boston University School of Medicine.	Boston, Mass.	1869	1873	I. T. Talbot, M. D., 66 Marlborough St., Boston, Mass.	8 m'nths. Oct. 5.	3 & 4	113	35	223	33	9	20	100,000	$40,000	$35,000	11,439	I. T. Talbot, M. D., Walt. Wesselhoeft, M. D.
5 Michigan University Hom. Department.	Ann Arbor, Mich.	1875	1875	E. C. Franklin, M. D., Ann Arbor, Mich.	9 m'nths. Oct. 1.	3	64	26	59	4	3	1				10,000	E. C. Franklin, M. D., H. C. Allen, M. D.
6 Homœopathic Medical College of Missouri	St. Louis, Mo.	1857	1858	G. S. Walker, M. D., 2809 Washington Ave., St. Louis, Mo.	5 m'nths. Oct. 1.	2	54	25	340	13	13	0	Leased.	None.	None.	3,600	G. S. Walker, M. D., P. G. Valentine, M. D.
7 New York Homœop. Medical College.	New York, N. Y.	1859	1859	J. W. Dowling, M. D., 313 Madison Ave., New York, N. Y.	5 m'nths. Oct. 4.	3	122	33	697	21	14	7	"	$5,000	None.	Varies	J. W. Dowling, M. D., T. F. Allen, M. D.
8 New York Medical Coll. and Hospital for Women.	New York, N. Y.	1860	1860	Mrs. C. S. Lozier, M. D., 22d W. 14th St., New York, N. Y.	6 m'nths. Oct. 11.	3	34	6	141	15	9	6					S. Lilienthal, M. D., C. S. Lozier, M. D.
9 Homœopathic Hosp. College.	Cleveland, O.	1849	1849	N. Schneider, M. D., 385 Euclid Ave., Cleveland, O.	22 wks. Sept. 25.	2	130	49	1,200	9	9		$20,000	None.	None.		N. Schneider, M. D., J. C. Sanders, M. D.
10 Pulte Medical College.	Cincinna'i, O.	1872	1872	J. D. Buck, M. D., 292 Race St. Cincinnati, O.	23 wks. Sept. 29.	2	87	22	222	11	8		50,000				G. C. McDermott, M. D., J. D. Buck, M. D.
11 Hahnemann Medical College.	Phil'd'lph'a Pa.	1848	1848	A. R. Thomas, M. D., 1733 Chestnut St., Philadelphia, Pa.	5 m'nths. Oct. 1.	2 & 3	208	75	1,286	20	11	9	Hospit'l Prop'ty	None.		$15,727	B. F. Betts, M. D., Pemberton Dudley, M. D.
						Total,	1,192	337	4,922	159	100	56	$230,000	$45,000	$53,000	$55,766	

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SPECIAL SCHOOLS.

1 School of the N. Y. Ophthalmic Hosp.	New York, N. Y.	1852	1852	Geo. S. Norton, M. D., 134 West 34th St., New York, N. Y.	6 m'nths. Oct. 1.	1	5	3	39	10	4	6					
2 Missouri School of Midwifery and Diseases of Children.	St. Louis, Mo.	1875	1875	W. C. Richardson, M. D., 721 Chestnut St., St. Louis, Mo.	28 wks. 1st Mon. in Sept.	1	21	15	143	4	4		$5,000		$600	$1,800	

HOMŒOPATHIC JOURNALS IN THE UNITED STATES.

Name of Journal.	Name and Address of Publisher.	Name and Address of Editor.	When established.	How often Published.	No. of Copies Published.	Form.	Yearly No. of pages.	Subscription price.	Delegates.
1 Medical Investigator.	Duncan Brothers, Chicago, Ill.	T. C. Duncan, 131 South Clarke St., Chicago, Ill.	1856	Semimonthly.		Octavo.	1,536	$3.00	T. C. Duncan, M. D.
2 The Clinique.	T. S. Hoyne, 1634 Wabash Ave., Chicago, Ill.	R. Ludlam, 526 Wabash Ave., Chicago, Ill.	1880	Monthly.	2,500	Octavo.	400	1.00	R. Ludlam, M. D.
3 Medical Counselor.	W. A. Chatterton 83 5th Ave , Chicago, Ill.	H. P. Arndt, Grand Rapids, Mich.	1879	Monthly.	1,400	Octavo.	576	2.00	H. P. Arndt, M. D.
4 The Chicago Medical Review.	W. A. Chatterton, 83 5th Ave., Chicago, Ill.		1880	Bimonthly.	4 300	Octavo.	96	0.50	H. P. Arndt, M. D.
5 New England Medical Gazette.	Otis Clapp & Son, 3 Beacon St., Boston, Mass.	H. C. Clapp, M. D., 16 Concord Sq., Boston, Mass.	1866	Monthly.	800	Octavo.	384	1.00	H. C. Clapp, M. D.
6 American Observer.	E. A. Lodge, Detroit, Mich.	E. A. Lodge and staff, Detroit, Mich.	1864	Monthly.	1,200	Octavo.	672	2.50	
7 St Louis Clinical Review	Maynard & Co., N. 4th St., St. Louis, Mo.	P. G. Valentine, Chouteau Ave., St. Louis, Mo.	1878	Monthly.	1,000	Octavo.	480	2.00	P. G. Valentine, M. D.
8 Homœopathic News.	H. C. J. Luyties, 306 No. 5th St., St. Louis, Mo.	C. H. Goodman, 2619 Pine St., St. Louis, Mo.	1879	Monthly.	1,500	Octavo.	288	1.00	
9 North American Journal of Homœopathy.	Boericke & Tafel, 145 Grand St., N. Y.	S. Lilienthal, 230 West 25th St., N. Y.	1851	Quarterly.	550	Octavo.	704	4.00	S. Lilienthal, M. D.
10 Homœopathic Times.	The Editors, 18 West 23d St., New York.	E. Guernsey. M. D., 18 West 23d St., N. Y. A. K. Hills, M. D., 465 5th Ave., N. Y. J. B. Gilbert, M. D., 23 West 37th St, N. Y.	1873	Monthly.	2,000	Royal Octavo.	480	3.00	

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HOMŒOPATHIC JOURNALS IN THE UNITED STATES.—*Continued.*

Name of Journal.	Name and Address of Publisher.	Name and Address of Editor.	When established.	How often Published.	No. of Copies Published.	Form.	Yearly No. of pages.	Subscription price.	Delegates.
11 American Homœopath.	A. L. Chatterton Pub. Co., 114 Nassau St., N. Y.	E. C. Blumenthal, 54 W. 45th St., N. Y.	1877	Monthly.	2,000	Octavo.	672	2.00	
12 American Journal of Electrology and Neurology.	Boericke & Tafel, 145 Grand St., N. Y.	John Butler, 102 East 22d St, N. Y.	1879	Quarterly.	500	Octavo.	320	2.00	
13 Homœopathic Journal of Obstetrics.	A. L. Chatterton Pub. Co., 114 Nassau St, N. Y.	H. Minton, 106 Ioralemon St., Brooklyn, N. Y.	1879	Quarterly.		Octavo.	512	4.00	H. Minton, M. D.
14 Homœopathic Expositor.	E. J. Morgan, Jr., Ithaca, N. Y.	E. J. Morgan, Jr., Ithaca, N. Y.	1878	Quarterly.	3,500	Octavo.	128	.50	
15 Cincinnati Medical Advance.	G. P. Geppert, 305 Race St., Cincinnati, O.	T. P. Wilson, Ann Arbor, Mich.	1873	Monthly.	1,200	Octavo.	768	2.00	T. P. Wilson, M. D.
16 Hahnemannian Monthly.	Hahnemann Club of Phila. B. W. James (bus. man'r). N. E. cor. 18th & Green Sts., Phila., Pa.	Pemberton Dudley, 15th & Master Sts., Phila., Pa. E. A. Farrington, 1738 Green St., Phila., Pa.	1865	Monthly.	1,000	Octavo.	768	3.00	B. W. James, M. D.
				Total....	23,450		8,784	$33.50	
		HOMŒOPATHIC DIRECTORIES.							
1 North American Homœo. Directory.	J. Pettet, M. D., Cleveland, O.	J. Pettet, M. D.	1875	Biennially.	6,500	Octavo.	120	Free.	J. Pettet, M. D.
2 Directory of Illinois, Indiana, Missouri, & Kansas.	T. S. Hoyne, M. D., 1634 Wabash Ave., Chicago.		1872	Annually.	5,000	Octavo.	32 to 36	Free.	T. S. Hoyne, M. D.
3 Directory of Iowa, Minnesota, and Wisconsin.	Iowa City Publishing Co.			Annually.	5,000	Octavo.	16	Free.	
4 Directory of Michigan.	R. B. House, M D., Tecumseh, Mich.	R. B. House, M. D.	1879	Annually.	3,000	Octavo.	16 to 24	Free.	R. B. House, M. D.
5 Directory of New England.	Otis Clapp & Son, 3 Beacon St., Boston, Mass.	J. W. Clapp, M. D.	1876	Biennially.	2,000	Octavo.	8 to 10	Free.	
6 Chatterton's Medical Reg. of N. Y. and N. E.	A. L. Chatterton, 114 Nassau St., N. Y.				2,500	Duodecimo.	114	1.00	
7 Directory of Pennsylvania and Middle States.	W. T. Bruce.								

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THE NATIONAL ASSOCIATION.

The American Institute of Homœopathy is sufficiently broad in its scope to include every homœopathic physician, as well as institution, in the United States. Its publications should be so valuable that every physician should feel it essential for him to possess them, and its associations so extensive and important that every member of our school would wish to be connected with it. At present the number of members is less than a thousand, while it might have at least three times that number. How best to increase the membership should engage the attention of all our associates.

One other national society, the American Ophthalmological and Otological Society, has been formed, and holds its session at the time and place of the Institute meeting. It has some forty members, with annual dues of three dollars. As this society covers over precisely the same ground occupied by one of the bureaus of the Institute, it is questionable whether the work can best be done in one or two societies. The publications made by a separate society, at additional cost, reach a very limited number, while, if incorporated in the transactions of the Institute, they would be much more widely circulated.

STATE SOCIETIES.

Already twenty-three societies are reported, and seventeen of these have received Acts of incorporation from their several States. All of the Northern States, with the exception of Oregon and a few of those recently admitted, have State societies. Probably these exceptions will soon be removed. Of the Southern States, three only, Maryland, Tennessee, and Missouri, have State organizations. Most of these have a sufficient number of homœopathic physicians to form a profitable State society, and it is hoped that such action will be taken, and reported to the Institute at its next session, by Virginia, Kentucky, Louisiana, Texas, and perhaps others.

LOCAL SOCIETIES.

Ninety-two local societies and seven medical clubs are reported. Some of these meet regularly and frequently, and are of great service. Others are merely nominal organizations, without vigor or usefulness. There need be no question as to the importance of

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local societies, in a profession whose practice, as a rule, keeps its members apart. The daily life of every physician finds observations and experiences valuable to his associates, and in no way can these be more usefully related than in the frequent and informal meetings of local medical societies. To make these successful, the first requisite is an earnest, faithful, working secretary, who will urge members to be present and offer their experiences and thoughts at the meetings. Wherever a dozen homœopathic physicians reside within practical range of each other, such a society can be conducted.

HOSPITALS.

No one thing has given greater surprise and pleasure to the Bureau than the individual and aggregate reports of the different hospitals and infirmaries. The number of these in the United States is much larger than is usually supposed. Of the thirty-eight hospitals under homœopathic treatment, twenty-seven have made reports to the Bureau. These contain 1,682 beds, and in the past year have treated 14,749 patients, with a mortality of 377, or about two and a half per cent. The cost of establishing and building twenty-one of these hospitals, as already paid, has been $1,549,175. In addition to these there are other hospitals, built by States and cities at large expense, such as the Ward's Island Homœopathic Hospital, which would largely increase the aggregate amount of cost.

The need for additional homœopathic hospitals is felt in nearly all our large cities, and though oftentimes the magnitude of the work seems to paralyze and discourage effort, yet everywhere there are generous patrons of our system, who need but to be asked in order to render their aid in charitable hospital work. The next ten years can easily double our resources in this direction.

DISPENSARIES.

Of the twenty-nine dispensaries known to the Bureau, twenty-five have reported the work done this last year. These have treated 117,564 patients, with 282,772 prescriptions. One hundred thousand people have in the past year received through these charities the blessings of homœopathy! When we consider the small amount required to support these dispensaries, is it not practicable to establish them in all our large cities?

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COLLEGES.

The work done by medical colleges for the community is little thought of, or greatly underestimated; and we hardly realize the importance to homœopathy of our medical schools. The number of physicians that change to homœopathic practice after having received their education, and established themselves as allopathic physicians, is comparatively small; and though there are brilliant exceptions to the rule, yet many of these have heretofore proved unsuccessful as allopaths. It is greatly to the credit of homœopathy that in many instances a change of practice has turned failure into success. The knowledge of homœopathy gained by this class of physicians cannot equal the careful and systematic training given in our colleges.

In the eleven homœopathic schools, 1,192 students have been in attendance, and 387 have been graduated the past year. The whole number of alumni belonging to these colleges is 4,922. Thus we see how greatly these schools have added to our strength, and it is of the utmost importance that this Institute and the profession should use their influence to support and improve them. The medical schools of this country are, as a rule, but indifferently endowed; they are left for the profession to support. No endowments or contributions are made by the laity, to improve or increase the facilities for medical teaching. Schools, academies, seminaries, and colleges receive the generous support of the public; but the medical profession — that which, more than any other, holds the health and lives of the community in its keeping — is left entirely to itself to gain instruction as best it may. Hospitals and dispensaries are supported for the benefit of the poor at immense expense; but not a dollar is given to make better physicians, and thereby provide for the greater public safety. Would not generous individuals, if properly appealed to, willingly contribute to the maintenance of our medical schools?

JOURNALS.

The law of supply and demand already gives sixteen homœopathic journals, regularly issued in the United States. The cost of subscription to all of these is $33.50 per annum; the number of pages furnished is 8,784; the number of copies published is 23,450. All of these journals present valuable ideas and facts which the

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physician can hardly afford to be without; yet, if the several journals were more freely sustained by the profession, they could undoubtedly be greatly improved in character.

DIRECTORIES.

The most complete list of homœopathic physicians in the United States is that kept by the New York Homœopathic Mutual Life Insurance Company. It contains now about six thousand names. Various unsatisfactory, as well as unremunerative, attempts have been made to publish a directory of the United States. Local or State directories have been published for several years, which have been quite complete for the section included by them. While it is not the purpose or province of the Institute to publish a general directory of physicians not members, yet if the various parties who publish separate directories could combine, and make one complete general directory of the United States, it would be very valuable to the whole profession.

STATISTICS.

If every homœopathic society and institution in our country would carefully report its doings annually to the American Institute, we could from year to year better understand our actual growth and progress. Let every physician, and especially every member of the Institute, realize his duties: —

1. In sustaining those institutions already established, and keeping them in a state of active usefulness.
2. In establishing new ones wherever there is a clear and emphatic demand for them.
3. In seeing that every institution is yearly represented by a delegate to the American Institute of Homœopathy.
4. In securing and forwarding proper yearly reports of all these institutions to the Bureau of Organization, Registration, and Statistics.
5. In increasing the number of members, and promoting the usefulness of the American Institute of Homœopathy.

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APPENDIX.

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APPENDIX.

AMERICAN INSTITUTE OF HOMŒOPATHY.

A BRIEF HISTORY OF ITS ORGANIZATION, WITH A CHRONOLOGICAL REGISTER OF ITS OFFICERS, TO THE PRESENT TIME.

In July, 1843, the New York Homœopathic Physicians' Society appointed a committee to issue invitations to the homœopathic physicians of the United States, to meet in general convention in the city of New York, for the purpose of forming a National Homœopathic Medical Society. The time fixed for holding the convention was April 10th, 1844. The invitation was responded to by a considerable number of the leading homœopathic practitioners of the country, who, according to previous arrangements, convened in the Lyceum of Natural History, in New York city, N. Y., on the 10th day of April, 1844, the eighty-ninth anniversary of the birth of the illustrious Hahnemann.

The convention was organized by electing Constantine Hering, M.D., of Philadelphia, Pa., President; Josiah F. Flagg, M.D., of Boston, Mass., and William Channing, M.D., of New York, N. Y., Vice-Presidents; and Henry Dunnell, M.D., Secretary.

The following resolution was then offered, and unanimously adopted, viz.:

Resolved, That it is deemed expedient to establish a society, entitled "The American Institute of Homœopathy."

John F. Gray, M.D., was elected General Secretary of the Institute, and S. R. Kirby, M.D., Treasurer.

The convention, having accomplished the object for which it had assembled, on motion, it adjourned *sine die.*

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Immediately after the adjournment of the convention, on the evening of the 10th day of April, 1844, at the call of John F. Gray, M.D., General Secretary-elect, the First Session of the American Institute of Homœopathy was held. Josiah F. Flagg, M.D., of Boston, Mass., was elected President, and A. Gerrold Hull, M.D., of New York, N. Y., Provisional Secretary.

OFFICERS OF THE INSTITUTE, FROM ITS ORGANIZATION TO THE PRESENT DATE.

First Session.

(*Held in New York, N. Y., April 10th*, 1844.)

Josiah F. Flagg, M.D., of Boston, Mass., President.

John F. Gray, M.D., of New York, N. Y., General Secretary.

A. Gerrold Hull, M.D., of New York, N. Y., Provisional Secretary.

S. R. Kirby, M.D., of New York, N. Y., Treasurer.

Second Session.

(*Held in New York, N. Y., May 14th*, 1845.)

Jacob Jeanes, M.D., of Philadelphia, Pa., President.

Edward Bayard, M.D., of New York, N.Y., General Secretary.

R. A. Snow, M.D., of New York, N. Y., Provisional Secretary.

S. R. Kirby, M.D., of New York, N.Y., Treasurer.

Third Session.

(*Held in Philadelphia, Pa., May 13th*, 1846.)

S. R. Kirby, M.D., of New York, N. Y., President.

Edward Bayard, M.D., of New York, N. Y., General Secretary.

R. A. Snow, M.D., of New York, N. Y., Provisional Secretary.

S. R. Kirby, M.D., of New York, N. Y., Treasurer.

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Fourth Session.

(*Held in Boston, Mass., June 9th*, 1847.)

F. R. McManus, M.D., of Baltimore, Md., President.

Edward Bayard, M.D., of New York, N. Y., General Secretary.

R. A. Snow, M.D., of New York, N. Y., Provisional Secretary.

S. R. Kirby, M.D., of New York, N. Y., Treasurer.

Fifth Session.

(*Held in New York, N. Y., June 14th*, 1848.)

Walter Williamson, M.D., of Philadelphia, Pa., President.

Edward Bayard, M.D., of New York, N. Y., General Secretary.

R. A. Snow, M.D., of New York, N. Y., Provisional Secretary.

S. R. Kirby, M.D., of New York, N. Y., Treasurer.

Sixth Session.

(*Held in Philadelphia, Pa., June 13th*, 1849.)

Samuel Gregg, M.D., of Boston, Mass., President.

Alvin E. Small, M.D., of Philadelphia, Pa., General Secretary.

William P. Esrey, M.D., of Philadelphia, Pa., Provisional Secretary.

S. R. Kirby, M.D., of New York, N. Y., Treasurer.

Seventh Session.

(*Held in Albany, N. Y., June 12th*, 1850.)

Edward Bayard, M.D., of New York, N. Y., President.

Alvin E. Small, M.D., of Philadelphia., Pa., General Secretary.

G. W. Swazey, M.D., of Springfield, Mass., Provisional Secretary.

S. R. Kirby, M.D., of New York, N. Y., Treasurer.

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Eighth Session.

(*Held in New Haven, Conn., June 11th*, 1851.)

William E. Payne, M.D., of Bath, Me., President.

G. W. Swazey, M.D., of Springfield, Mass., General Secretary.

Charles C. Foote, M.D., of New Haven, Conn., Provisional Secretary.

S. R. Kirby, M.D., of New York, N. Y., Treasurer.

Ninth Session.

(*Held in Baltimore, Md., May 19th*, 1852.)

Elial T. Foote, M.D., of New Haven, Conn., President.

William A. Gardiner, M.D., of Philadelphia, Pa., General Secretary.

S. S. Guy, M.D., Brooklyn, N. Y., Provisional Secretary.

S. R. Kirby, M.D., New York, N. Y., Treasurer.

Tenth Session.

(*Held in Cleveland, Ohio, June 8th*, 1853.)

Richard Gardiner, M.D., of Philadelphia, Pa., President.

William A. Gardiner, M.D., of Philadelphia, Pa., General Secretary.

S. S. Guy, M.D., of Brooklyn, N. Y., Provisional Secretary.

S. R. Kirby, M.D., of New York, N. Y., Treasurer.

Eleventh Session.

(*Held in Albany, N. Y., June 7th*, 1854.)

Lyman Clary, M.D., of Syracuse, N. Y., President.

S. S. Guy, M.D., of Brooklyn, N. Y., General Secretary.

J. Redman Coxe, Jr., M.D., of Philadelphia, Pa., General Secretary.

A. S. Ball, M.D., of New York, N. Y., Treasurer.

Twelfth Session.

(*Held in Buffalo, N. Y., June 6th*, 1855.)

C. H. Skiff, M.D., of New Haven, Conn., President.

J. P. Dake, M.D., of Pittsburg, Pa., General Secretary.

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A. H. BEERS, M.D., of Buffalo, N. Y., Provisional Secretary.

S. S. GUY, M.D., of Brooklyn, N. Y., Treasurer.

THIRTEENTH SESSION.

(*Held in Washington, D. C., June 4th*, 1856.)

G. W. SWAZEY, M.D., of Springfield, Mass., President.

F. R. MCMANUS, M.D., of Baltimore, Md., General Secretary.

J. MIDDLETON, M.D., of Baltimore, Md., Provisional Secretary.

S. S. GUY, M.D., of Brooklyn, N. Y., Treasurer.

FOURTEENTH SESSION.

(*Held in Chicago, Ill., June 3d*, 1857.)

J. P. DAKE, M.D., of Pittsburg, Pa., President.

D. S. SMITH, M.D., of Chicago, Ill., General Secretary.

G. E. SHIPMAN, M.D., of Chicago, Ill., Provisional Secretary.

S. S. GUY, M.D., of Brooklyn, N. Y., Treasurer.

FIFTEENTH SESSION.

(*Held in Brooklyn, N. Y., June 2d*, 1858.)

D. S. SMITH, M.D., of Chicago, Ill., President.

WILLIAM E. PAYNE, M.D., of Bath, Me., General Secretary.

E. T. RICHARDSON, M.D., of Brooklyn, N. Y., Provisional Secretary.

S. S. GUY, M.D., of Brooklyn, N. Y., Treasurer.

SIXTEENTH SESSION.

(*Held in Boston, Mass., June 1st*, 1859.)

P. P. WELLS, M.D., of Brooklyn, N. Y., President.

H. D. PAINE, M.D., of Albany, N. Y., General Secretary.

I. T. TALBOT, M.D., of Boston, Mass., Provisional Secretary.

C. H. SKIFF, M.D., of New Haven, Conn., Treasurer.

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Seventeenth Session.

(*Held in Philadelphia, Pa., June 2d*, 1860.)

E. C. Witherell, M.D., of Cincinnati, Ohio, President.

Jacob Beakley, M.D., of New York, N. Y., General Secretary.

Henry M. Smith, M.D., of New York, N. Y., Provisional Secretary.

C. H. Skiff, M.D., of Brooklyn, N. Y., Treasurer.

Eighteenth Session.

(*Held in Cincinnati, Ohio, June 7th*, 1865.)*

S. S. Guy, M.D., of Brooklyn, N. Y., President.

I. T. Talbot, M.D., of Boston, Mass., Vice-President.†

G. D. Beebe, M.D., of Chicago, Ill., General Secretary.

William Tod Helmuth, M.D., of St. Louis, Mo., Provisional Secretary.

D. S. Smith, M.D., of Chicago, Ill., Treasurer.

Nineteenth Session.

(*Held in Pittsburg, Pa., June 6th*, 1866.)

J. S. Douglas, M.D., of Milwaukee, Wis., President.

S. R. Beckwith, M.D., of Cleveland, Ohio, Vice-President.

I. T. Talbot, M.D., of Boston, Mass., General Secretary.

Henry B. Clarke, M.D., of New Bedford, Mass., Provisional Secretary.

E. M. Kellogg, M.D., of New York, N. Y., Treasurer.

Twentieth Session.

(*Held in New York, N. Y., June 4th*, 1867.)

William Tod Helmuth, M.D., of St. Louis, Mo., President.

P. P. Wells, M.D., of Brooklyn, N. Y., Vice-President.

I. T. Talbot, M.D., of Boston, Mass., General Secretary.

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* No sessions were held during the rebellion.

† By a change of the by-laws the office of vice-president was instituted at this session.

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HORACE M. PAINE, M.D., of Albany, N. Y., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

TWENTY-FIRST SESSION.

(*Held in St. Louis, Mo., June 2d,* 1868.)

HENRY D. PAINE, M.D., of New York, N. Y., President.

T. G. COMSTOCK, M.D., of St. Louis, Mo., Vice-President.

I. T. TALBOT, M.D., of Boston, Mass., General Secretary.

H. L. CHASE, M.D., of Cambridge, Mass., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

TWENTY-SECOND SESSION.

(*Held in Boston, Mass., June 8th,* 1869.)

REUBEN LUDLAM, M.D., of Chicago, Ill., President.

D. H. BECKWITH, M.D., of Cleveland, Ohio, Vice-President.

I. T. TALBOT, M.D., of Boston, Mass., General Secretary.

TIMOTHY F. ALLEN, M.D., of New York, N. Y., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

TWENTY-THIRD SESSION.

(*Held in Chicago, Ill., June 7th,* 1870.)

DAVID THAYER, M.D, of Boston, Mass., President.

J. J. YOULIN, M.D., of Jersey City, N. J., Vice-President.

REUBEN LUDLAM, M.D., of Chicago, Ill., General Secretary.

T. C. DUNCAN, M.D., of Chicago, Ill., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

TWENTY-FOURTH SESSION.

(*Held in Philadelphia, Pa., June 6th,* 1871.)

D. H. BECKWITH, M.D., of Cleveland, Ohio, President.

J. D. TEMPLE, M.D., of St. Louis, Mo., Vice-President.

REUBEN LUDLAM, M.D., of Chicago, Ill., General Secretary.

T. C. DUNCAN, M.D., of Chicago, Ill., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

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Twenty-fifth Session.

(*Held in Washington, D. C., June* 21*st*, 1872.)

I. T. Talbot, M.D., of Boston, Mass., President.

J. J. Youlin, M.D., of Jersey City, N. J., Vice-President.

Robert J. McClatchey, M.D., of Philadelphia, Pa., General Secretary.

Bushrod W. James, M.D., of Philadelphia, Pa., Provisional Secretary.

E. M. Kellogg, M.D., of New York, N. Y., Treasurer.

Twenty-sixth Session.

(*Held in Cleveland, Ohio, June* 3*d*, 1873.)

Alvin E. Small, M.D., of Chicago, Ill., President.

J. C. Burgher, M.D., of Pittsburg, Pa., Vice-President.

Robert J. McClatchey, M.D., of Philadelphia, Pa., General Secretary.

Bushrod W. James, M.D., of Philadelphia, Pa., Provisional Secretary.

E. M. Kellogg, M.D., of New York, N. Y., Treasurer.

Twenty-seventh Session.

(*Held at Niagara Falls, N. Y., June* 9*th*, 1874.)

John J. Youlin, M.D., of Jersey City, N. J., President.

N. Schneider, M.D., of Cleveland, Ohio, Vice-President.

Robert J. McClatchey, M.D., of Philadelphia, Pa., General Secretary.

Bushrod W. James, M.D., of Philadelphia, Pa., Provisional Secretary.

E. M. Kellogg, M.D., of New York, N. Y., Treasurer.

Twenty-eighth Session.

(*Held at Put-in-Bay, Ohio, June* 15*th*, 1875.)

William H. Holcombe, M.D., of New Orleans, La., President.

L. E. Ober, M.D., of La Crosse, Wis., Vice-President.

Robert J. McClatchey, M.D., of Philadelphia, Pa., General Secretary.

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BUSHROD W. JAMES, M.D., of Philadelphia, Pa., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

TWENTY-NINTH SESSION.

(*Held at Philadelphia, Pa., June 26th*, 1876.)

CARROLL DUNHAM, M.D., of Irvington-on-Hudson, N. Y., President.

E. C. FRANKLIN, M.D., of St. Louis, Mo., Vice-President.

ROBERT J. MCCLATCHEY, M.D., of Philadelphia, Pa., General Secretary.

T. C. DUNCAN, M.D., of Chicago, Ill., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

THIRTIETH SESSION.

(*Held at Lake Chautauqua, N. Y., June 26th*, 1877.)

E. C. FRANKLIN, M.D., of St. Louis, Mo., President.

T. P. WILSON, M.D., of Cincinnati, Ohio, Vice-President.

ROBERT J. MCCLATCHEY, M.D., of Philadelphia, Pa., General Secretary.

JOSEPH C. GUERNSEY, M.D., of Philadelphia, Pa., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

THIRTY-FIRST SESSION.

(*Held at Put-in-Bay, Ohio, June 18th*, 1878.)

JOHN C. BURGHER, M.D., of Pittsburg, Pa., President.

J. C. SANDERS, M.D., of Cleveland, Ohio, Vice-President.

ROBERT J. MCCLATCHEY, M.D., of Philadelphia, Pa., General Secretary.

JOSEPH C. GUERNSEY, M.D., of Philadelphia, Pa., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

THIRTY-SECOND SESSION.

(*Held at Lake George, N. Y., June 17th*, 1879.)

CONRAD WESSELHŒFT, M.D., of Boston, Mass., President.

N. FRANCIS COOKE, M.D., of Chicago, Ill., Vice-President.

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ROBERT J. MCCLATCHEY, M.D., of Philadelphia, Pa., General Secretary.

JOSEPH C. GUERNSEY, M.D., of Philadelphia, Pa., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

THIRTY-THIRD SESSION.

(*Held in Milwaukee, Wis., June* 15*th*, 1880.)

T. P. WILSON, M.D., of Ann Arbor, Mich., President.

GEORGE A. HALL, M.D., of Chicago, Ill., Vice-President.

J. C. BURGHER, M.D., of Pittsburg, Pa., General Secretary.

J. H. MCCLELLAND, M.D., of Pittsburg, Pa., Provisional Secretary.

E. M. KELLOGG, M.D., of New York, N. Y., Treasurer.

N. B.—The World's Homœopathic Convention was held in Philadelphia, Pa., under the auspices of the Institute, in conjunction with its Twenty-ninth Session, the officers of the Institute being constituted the officers of the convention.

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CONSTITUTION AND BY-LAWS.

CONSTITUTION.

(ADOPTED JUNE 10TH, 1874.)

ARTICLE I.—NAME AND OBJECT.

THIS Association shall be styled the AMERICAN INSTITUTE OF HOMŒOPATHY, and its object the improvement of homœopathic therapeutics and all other departments of medical science.

ARTICLE II.—MEMBERS.

The Institute shall be composed of those physicians who are already members, and of such others as may be hereafter chosen in conformity with the By-Laws.

ARTICLE III.—OFFICERS.

The officers of the Institute shall be a President, Vice-President, a General Secretary, a Provisional Secretary, and a Treasurer, with such other officers as shall be designated by the By-Laws, to be chosen at such time, in such manner, for such a period, and with such duties as these By-Laws shall ordain.

ARTICLE IV.—SEAL.

The Institute shall have and use one common seal, with a suitable device and inscription.

ARTICLE V.—AMENDMENTS.

This Constitution may be altered or amended by a vote of two-thirds of all the members present at the regular annual meeting, provided that notice of such alteration or amendment shall have been given in writing at a previous annual meeting of the Institute.

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BY-LAWS.

(ADOPTED JUNE 20TH, 1878.)

ARTICLE I.—MEETINGS.

THE Institute shall hold at least one session in each year, at such time and place as may be determined upon from time to time.

ARTICLE II.—OFFICERS.

SECTION 1. The officers shall be elected by ballot at each annual session of the Institute, and shall enter upon their respective duties the first day of January following.

SECTION 2. The officers of the Institute, viz., the President, Vice-President, General Secretary, Provisional Secretary, and Treasurer, shall constitute an Executive Committee, which shall arrange the business of the meetings, attend to matters of business not otherwise specially provided for, and perform such other duties as may by vote of the Institute devolve upon it.

SECTION 3. The General Secretary shall be paid an annual salary of five hundred dollars.

ARTICLE III.—DUTIES OF OFFICERS.

SECTION 1. The President shall preside at the meetings of the Institute, and perform the duties usually pertaining to his office, together with such others as may by vote of the Institute devolve upon him. He shall sign all certificates of membership. He shall deliver an address at the opening of each session on the progress of homœopathy during the year past, and make such suggestions as he may deem necessary for the Institute to take action on during the session.

SECTION 2. The Vice-President shall perform the duties of the President in his absence or disability.

SECTION 3. The General Secretary shall keep a record of the proceedings of the meetings, conduct the correspondence of the Institute, issue notices of meetings, notify candidates of their election, sign certificates of membership, and perform such other duties as the Institute may direct. It shall further be the duty of the Secretary to send to each homœopathic journal published in the country, within two months after the adjournment of an annual meeting, a list of the officers of the ensuing year and the members of its bureaus, and the titles of the subjects selected by said bureaus.

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SECTION 4. The Provisional Secretary shall assist the General Secretary, and in his absence perform his duties.

SECTION 5. The Treasurer shall receive all money belonging to the Institute, and make all disbursements under the recommendation of the Executive Committee. He shall furnish at each annual meeting a written report of the condition of the finances.

ARTICLE IV.—CENSORS.

At each annual session the Institute shall elect, by ballot, a board of five censors (three of whom shall constitute a quorum), who shall receive and examine the credentials of candidates for membership, and report to the Institute for election such as may be found properly qualified. The censors shall enter upon their duties on the first day of January following their election.

ARTICLE V.—MEMBERSHIP.

SECTION 1. Candidates for membership shall present to the Board of Censors a certificate of three members of the Institute that the applicant has pursued a regular course of medical studies, according to the requirements of the existing institutions of this country, and sustains a good moral character and professional standing. Such certificate shall state when and where the applicant obtained a diploma. If found qualified the candidate may be elected a member. No person shall be considered a member, however, before paying an admission fee of five dollars, and the annual dues, which shall entitle him to a certificate of membership.

SECTION 2. Any physician properly accredited as a delegate, shall be admitted during the session of the Institute to all the privileges of members, except voting and eligibility to office, on the following basis:

First. From every association composed of more than fifty members from different States, two delegates, with an additional delegate for every twenty members.

Second. From every State Society, two delegates, with an additional delegate for every twenty members.

Third. From every county or local society, one delegate.

Fourth. From every college, hospital, asylum for the insane, or dispensary, actually established, one delegate.

Fifth. From every medical journal published one delegate.

Such delegates shall be elected for the term of one year.

SECTION 3. Any foreign physician may be elected a Corresponding Member of the Institute at any annual meeting, and shall have all the privileges of members except voting and eligibility to office.

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SECTION 4. The Institute may, at any annual meeting, elect as Honorary Members, not to exceed five in one year, any foreign physicians who may be judged worthy from their superior attainments in medicine; provided that the names of persons proposed for Honorary Membership shall have been presented at a previous annual meeting. Such Honorary Members shall have all the privileges of members except voting and eligibility to office.

SECTION 5. All members of the Institute who have maintained twenty-five consecutive years of membership shall be considered *Senior Members*, and be exempt from the payment of annual dues; and the names of such members shall be printed first in the list of members, in capital letters.

SECTION 6. Of State Societies represented in the Institute, the Presidents shall be *ex-officio* Vice-Presidents, and the Recording Secretaries shall be *ex-officio* Corresponding Secretaries of the Institute, and these officers shall communicate through the various bureaus any facts or information concerning the condition of these societies, and the progress of medicine and homœopathy in their several States.

SECTION 7. The Institute may, at any annual meeting, elect as Honorary Associate Members, not to exceed three in any one year, any persons, not members of the medical profession, who have in any way been of special service to science or humanity, and particularly those who have been special patrons of homœopathy; and said Honorary Associate Members shall have all the privileges of Honorary Members.

ARTICLE VI.—DUES.

SECTION 1. Members shall pay annually the sum of five dollars toward defraying the expenses of the Institute. The *Proceedings of the Institute* will be sent to those members only who have paid their dues.

ARTICLE VII.—BUREAUS AND COMMITTEES.

SECTION 1. The following BUREAUS shall be appointed as hereinafter provided for:

a. Materia Medica, Pharmacy, and Provings.

b. Clinical Medicine, embracing Diagnosis and General and Special Therapeutics.

c. Obstetrics.

d. Gynæcology.

e. Pædology.

f. General Sanitary Science, Climatology, and Hygiene.

g. Surgery.

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h. Anatomy and Physiology.
i. Microscopy and Histology.
j. Psychological Medicine.
k. Ophthalmology, Otology, and Laryngology.
l. Organization, Registration, and Statistics.

SECTION 2. Each of these bureaus shall consist of at least seven members.

SECTION 3. Each bureau, in its annual report, shall present a *résumé* of discoveries and progress in their respective fields, together with papers upon their special subjects selected for inquiry and discussion.

SECTION 4. The following STANDING COMMITTEES shall be appointed, as hereinafter provided for:

a. Legislation.
b. Medical Literature.
c. Foreign Correspondence.
d. Medical Education.
e. An Intercollegiate Committee.

SECTION 5. Each of these committees shall consist of at least five members, except the Intercollegiate Committee.

SECTION 6. Immediately upon the closing of a bureau the President shall appoint a chairman for the ensuing year; and the chairman so appointed shall form his own bureau, handing to the President a list of its members, so that it may be announced before the close of the session.

SECTION 7. The chairman of each bureau, as soon as possible after appointment, shall call his associates together and organize his bureau by the appointment of a secretary; and, being duly organized, the bureau shall select a special subject upon which to labor, and report at the next meeting of the Institute.

SECTION 8. No bureau shall submit for discussion and publication any papers not relating to the special subject agreed upon at the beginning of the year, except such as may be included in the general *résumé.*

SECTION 9. No report or paper shall be received by the Institute in an incomplete or unfinished condition; and no paper shall be published in the *Transactions* which has been previously published, or which is not handed to the General Secretary within thirty days after the close of the session.

SECTION 10. Immediately upon the reception and disposition of the report of a standing committee, the President shall appoint the committee for the following year, except the Intercollegiate Committee, which shall be made up of two delegates from each college.

SECTION 11. No paper shall be read from any bureau or com-

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mittee requiring over fifteen minutes, without unanimous consent, but an abstract of the same may be presented.

SECTION 12. The *Transactions* of the Institute shall be issued by the General Secretary within three months after the close of the session, and copies shall be delivered to those entitled to them without individual expense.

SECTION 13. All reports by delegates from various societies and institutions shall be limited to five minutes each.

SECTION 14. In all discussions no speaker shall be allowed more than five minutes, nor to speak more than once upon the same subject, without a vote of consent, taken in the usual manner.

SECTION 15. Members neglecting the payment of dues for three years, after proper notification from the Treasurer, shall have their names dropped from the roll of membership.

SECTION 16. The annual meeting of this body shall consist of one general morning session daily for the transaction of the business of the Institute, and during the afternoon or evening of each day its several bureaus shall hold sectional meetings for the more complete performance of their duties.

SECTION 17. The Executive Committee shall constitute the Committee of Publication.

SECTION 18. The election of officers for the ensuing year, and the determination of the next place for the meeting of the Institute, shall take place at twelve o'clock on the last day of the session.

ARTICLE VIII.

SECTION 1. Members violating the provisions of the Code of Ethics adopted by the Institute, shall be expelled, or placed under censure, by a vote of two-thirds of the members present, upon satisfactory proof of such violation.

ARTICLE IX.—AMENDMENTS.

These By-Laws may be altered or amended by a vote of two-thirds of the members present at any annual meeting.

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RESOLUTIONS.

Adopted June 8, 1854.

Resolved, That the pharmaceutists of the homœopathic school be recommended to use, in the preparation of drugs by trituration, the proportions of ten grains of the drug to ninety grains of sugar of milk; and, for the sake of uniformity, to retain the numerical designation adopted by Hahnemann, and continued by the majority of homœopathic physicians.

Adopted June 4, 1857.

Resolved, That it is the duty of the American Institute of Homœopathy to extend a fostering care to the homœopathic medical colleges of the United States, and exert its influence in directing students of medicine who are seeking admission to the honors of the profession to their halls for instruction.

Resolved, That the American Institute of Homœopathy does not necessarily indorse the doctrines contained in the reports of committees by accepting and publishing such reports with the Proceedings.

Adopted June 7, 1867.

Resolved, That, in the organization of life insurance companies which discriminate in favor of practical homœopathists, we recognize an important instrumentality, which by showing the superiority of homœopathic treatment, will contribute to the more rapid adoption of the principles of medical science promulgated by the illustrious Hahnemann; and that, whenever practicable, the members of this Institute will give to such organization a united and cordial support.

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Adopted June 9, 1869.

Resolved, That the Bureau of Clinical Medicine be requested to give attention to the collection of clinical verifications of the symptoms contained in our Materia Medica, and to include such verifications in their reports, with whatever details they deem proper, giving credit to the authors.

Resolved, That the Institute invite State societies to co-operate in this work of clinical verification of the Materia Medica.

Adopted June 8, 1870.

Resolved, That each member of the American Institute will best subserve the interest of homœopathic medicine by using great care to avoid accepting any student of medicine into his office who does not or cannot give evidence of possessing the preliminary education recommended in the report of the Committee on Education.

Resolved, That the resolution relating to qualification apply to all students whose term of pupilage shall commence subsequent to the year 1870, and that every effort be made to acquaint the profession at large with the action of the Institute.

Adopted June 9, 1874.

Resolved, That hereafter all provings by a single prover, presented through the Bureau of Materia Medica, Pharmacy, and Provings, be referred back to the bureau, to be retained by them until a sufficient number of provings are obtained to warrant the bureau in collating the same and presenting them to the Institute for publication; and such collation and presentation shall be a part of the duty of that bureau.

Adopted June 12, 1874.

Resolved, That the bureaus of the Institute that pertain to practical medicine and surgery be hereafter arranged in rotation, so that each one may come first in its turn in successive years.

Adopted June 15, 1875.

Resolved, That *Sectional Meetings* of any bureau may be held at the call of the chairman of that bureau, provided such meetings are not held during the sittings of the Institute.

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Whereas, It is now a difficult matter to obtain mortuary reports from many of our cities and towns, therefore

Resolved, That this body would recommend to the members of the Institute, that they, in their respective cities and towns, where published reports are to be had, obtain and furnish annually to the Bureau of General Sanitary Science, Climatology, and Hygiene, a copy of such published reports; and, further, that when such reports are made up, state statistical mortuary reports be likewise sent to this bureau.

Resolved, That in states, cities, and towns where these reports are not made and published, they be urged to publish them for the general good of the country, as well as for local advantages.

ADOPTED JUNE 27, 1877.

Resolved, That all papers rejected by the Committee of Publication, and not published with the *Transactions* of the Institute, be referred back to their authors by the General Secretary, to be disposed of as they may see fit.

ADOPTED JUNE 29, 1877.

Resolved, *First*, That the Committee of Arrangements, in preparing the Order of Business for future meetings of the Institute, be requested to set apart a certain time for hearing reports from delegates from institutions and societies who may be present at the meeting, such reports to be limited to five minutes each.

ADOPTED JUNE 26, 1879.

Resolved, That the General Secretary shall hereafter furnish to the homœopathic journals, editorial copies of the *Transactions* of this Institute.

ADOPTED JUNE 15, 1880.

Resolved, That the report of the Bureau of Organization, Registration, and Statistics follow that of the Necrologist.

Resolved, That the selection of the time and place of meeting and the election of officers take place at noon of the third day of the session.

ADOPTED JUNE 17, 1880.

Resolved, That the reports of the colleges be made by the Bureau of Organization, Registration, and Statistics.

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MEMBERS.

The ? denotes that the residence is doubtful; the figures show the date of membership. Members are requested to inform the General Secretary of any change in the address of any of the members.

THE following is a part of the By-Laws adopted June 20th, 1878:

ARTICLE VII, SECTION 15: Members neglecting the payment of dues for three years, after proper notification from the Treasurer, shall have their names dropped from the roll of membership.

SENIOR MEMBERS.

1853. ANGELL, HENRY C., M.D., 16 Beacon St., Boston, Mass.
1846. ANNIN, J. D., M.D., Newark, N. J.
1844. BALL, ALONZO S., M.D., 43 W. 11th St., New York.
1853. BARNES, GEORGE W., M.D., San Diego, Cal.
1846. BARROWS, IRA, M.D., Providence, R. I.
1846. BAYARD, EDWARD, M.D., 8 W. 40th St., New York.
1846. BELCHER, GEORGE E., M.D., 522 Madison Av., N. Y.
1851. BELL, WILLIAM C., M.D., Middletown, Conn.
1846. BERENS, BERNARD, M.D., 1507 Arch St., Philadelphia.
1846. BERENS, JOSEPH, M.D., S. W. cor. Broad and Green Sts., Philadelphia.
1854. BISHOP, D. F., M.D., Lockport, N. Y.
1853. BISSELL, ARTHUR F., M.D., 157 Maiden Lane, New York.
1845. BOARDMAN, J. C., M.D., Trenton, N. J.
1854. BURGHER, J. C., M.D., 332 Penn Av., Pittsburg, Pa.
1854. CATE, S. M., M.D., Salem, Mass.
1844. CATOR, H. HULL, M.D., Roxbury, N. Y.
1847. CHASE, HIRAM L., M.D., Cambridge, Mass.

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1846. CLARK, ELIPHALET, M.D., Portland, Me.
1844. CLARK, LUTHER, M.D., 55 E. Newton St., Boston, Mass.
1850. CLARK, J. K., M.D., 11 Kearney St., San Francisco, Cal.
1854. CLARKE, HENRY B., M.D., New Bedford, Mass.
1851. COLLINS, H. A., M.D., Springfield, Mass.
1854. COOKE, N. F., M.D., 58 State St., Chicago, Ill.
1848. COOK, ABIJAH P., M.D., Hudson, N. Y.
1854. COX, JAMES W., M.D., Albany, N. Y.
1848. CUMMINGS. J. M., M.D., Portland, Me.
1852. DAKE, JABEZ P., M.D , 47 N. Vine St., Nashville, Tenn.
1844. DETWILER, H., M.D.. Easton, Pa.
1848. DONOVAN, THOMAS W., M.D., Tompkinsville, Staten Island, N. Y.
1846. EHRMAN, BENJAMIN, M.D., 46 W. 7th St., Cincinnati, O.
1846. EHRMAN, F., M.D., 84 W. 7th St., Cincinnati, O.
1855. FINCKE, BERNHARDT, M.D., 122 Livingston St., Brooklyn, N. Y.
1850. FOOTE, GEORGE F., M.D., Stamford, Conn.
1844. FULLER, MILTON, M.D., 35 Essex St., Boston, Mass.
1844. GALLUPE, WILLIAM, M.D., Bangor, Me.
1851. GAMBELL, W. P., M.D., 2 Rutland St., Boston, Mass.
1849. GARDINER, DANIEL R., M.D., Norristown, Pa.
1844. GRAY, JOHN F., M.D., Fifth Avenue Hotel, New York.
1848. GUERNSEY, EGBERT, M.D , 18 W. 23d St., New York.
1846. GUERNSEY, HENRY N., M.D., 1423 Chestnut St., Philadelphia.
1847. GUY, SAMUEL S., M.D., 179 Remsen St., Brooklyn, N. Y.
1846. HALLOCK, LEWIS, M.D., 34 E. 39th St., New York.
1852. HAMMOND, MILTON, M.D., 57 N. Paca St., Baltimore, Md.
1853. HELMUTH, WM. TOD, M.D., 299 Madison Av., New York.
1854. HOFMAN, H. H., M.D., 260 Penn Av., Pittsburg, Pa.
1846. HOLT, DANIEL, M.D., Lowell, Mass.
1854. JONES, ELIJAH U., M.D., Taunton, Mass.
1846. JONES, E. DARWIN, M.D., Albany, N. Y.
1853. JOSLIN, BENJAMIN F., M.D., 50 W. 29th St., New York.
1848. KEEP, LESTER, M.D., corner Gates and Vanderbilt Avs., Brooklyn, N. Y.
1853. KENYON, L. M., M.D., 86 W. Mohawk St., Buffalo, N. Y.
1844. KIMBALL, DANIEL S., M.D., Sackett's Harbor, N. Y.
1848. KOCH, A. W., M.D., 118 N. 12th St., Philadelphia.
1845. LIPPE, ADOLPH, M.D., 1204 Walnut St., Philada.
1844. MCMANUS, F. R., M.D., 71 Franklin St., Baltimore, Md.

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1845. McVicar, J. A., M.D., 130 E. 17th St., New York.
1848. Marcy, Erastus E., M.D., 307 5th Av., New York.
1851. Martin Joseph L., M.D., Baltimore, Md.
1844. Neidhard, Charles, M.D., 1511 Arch St., Philada.
1848. Norton, Lucian H., M.D., Bridgeport, Conn.
1844. Paine, Henry D., M.D., 26 W. 30th St., New York.
1850. Paine, Horace M., M.D., Albany, N. Y.
1848. Palmer, Miles W., M.D., 235 E. 18th St., New York.
1853. Parks, John M., M.D., Hamilton, O.
1854. Pomeroy, Thos. F., M.D., 143 Fort St., Detroit, Mich.
1847. Poole, Augustus, M.D., 232 W. 1st St., Oswego, N. Y.
1844. Pulte, Joseph H., M.D., 293 Walnut St., Cincinnati, O.
1854. Randel, Wm. H., M.D., 1 Clinton Sq., Albany, N. Y.
1848. Raymond, Jonas C., M.D., 248 Genesee St., Utica, N. Y.
1848. Reading, J. R., M.D., Somerton, Pa.
1846. Rhees, Morgan J., M.D., Wheeling, W. Va.
1847. Richardson, Edw. T., M.D., 141 Montague St., Brooklyn, N. Y.
1849. Rodman, William W., M.D., New Haven, Conn.
1844. Robinson, Horatio, M.D., Auburn, N. Y.
1848. Russell, George, M.D., 14 Lynde St., Boston, Mass.
1847. Sawyer, B. E., M.D., Haverhill, Mass.
1844. Schmidt, J., M.D., 92 Eutaw St., Baltimore, Md.
1847. Shackford, Rufus, M.D., Portland, Me.
1846. Shepard A., M.D., Glendale, O.
1854. Sisson, Edward R., M.D., New Bedford, Mass.
1853. Skiles, F. W., M.D., 160 Remsen St., Brooklyn, N. Y.
1846. Small, Alvin E., M.D., 583 Wabash Av., Chicago, Ill.
1848. Smith, D. S., M.D., 402 Michigan Av., Chicago, Ill.
1850. Springsteed, David, M.D., Albany, N. Y.
1846. Stevens, C. A., M.D., Scranton, Pa.
1852. Stevenson, T. C., M.D., Carlisle, Pa.
1848. Taft, Charles A., M.D., Hartford, Conn.
1853. Talbot, I. T., M.D., 66 Marlborough St., Boston, Mass.
1847. Thayer, David, M.D., 94 Boylston St., Boston, Mass.
1854. Walker, Charles H., M.D., Chelsea, Boston, Mass.
1844. Ward, Isaac M., M.D., Newark, N. J.
1844. Ward, Walter, M.D., Mount Holly, N. J.
1848. Warner, Lewis T., M.D., 39 E. 19th St., New York.
1854. Watson, Wm. H., M.D., 270 Genesee St., Utica, N. Y.
1848. Wells, Lucien B., M.D., 225 Genesee St., Utica, N. Y.
1844. Wells, P. P., M.D., 84 Clinton St., Brooklyn, N. Y.
1847. Whittle, Joshua F., M.D., Nashua, N. H.
1855. Wilder, Louis de V., M.D., 227 W. 34th St., N. Y.
1854. Wood, J. B., M.D., West Chester, Pa.

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1871. Adams, Myron H., M.D., Palmyra, N. Y.
1876. Adams, Reuben A., M.D., 31 N. Fitzhugh St., Rochester, N. Y.
1867. Albertson, J. A., M.D., 34 Eddy St., San Francisco, Cal.
1873. Allen, George D., M.D., Portland, Mich.
1872. Allen, Henry C., M.D., Ann Arbor, Mich.
1880. Allen, Charles, M.D., 417 7th St., S. W., Washington, D. C.
1871. Allen, Richard C., M.D., 4708 Paul St., Frankford, Philadelphia.
1866. Allen, Timothy F., M.D., 10 E. 36th Street, New York.
1875. Alling, C. P., M.D., Bradford, Pa.
1868. Alvord, Samuel, M.D., Chicopee Falls, Mass.
1879. Anderson, Jos. C., M.D., Mansfield, Ohio.
1876. Andrews, Purnell W., M.D., Camden, N. J.
1871. Andrews, William J., M.D., 13 E. Park St., Newark, N. J.
1869. Arcularius, Philip E., M.D., 57 E. 21st St., New York.
1880. Armstrong, William P., M.D., Lafayette, Ind.
1869. Arthur, A. A., M.D., Vergennes, Vt.
1874. Arthur, Charles, M.D., Scranton, Pa.
1858. Ashton, A. H., M.D., 730 S. 10th St., Philadelphia.
1871. Aten, Henry F., M.D., 34 Hanson Place, Brooklyn, N. Y.
1871. Bacon, Charles A., M.D., 130 E. 35th St., New York.
1867. Baer, O. P., M.D., Richmond, Ind.
1874. Baethig, Henry, M.D., 171 13th St., Buffalo, N. Y.
1870. Bagley, H. B., M.D., Seattle, Wash. Ter.
1879. Bailey, E. Stillman, M.D., 2131 Wabash Av., Chicago.
1875. Baker, Milton H., M.D., Highland Park, Ill.
1870. Baker, R. F., M.D., Davenport, Iowa.
1871. Baldwin, Aaron, M.D., 1017 M Street, N. W., Washington, D. C.
1876. Baldwin, Harry D., M.D., Montrose, Pa.
1857. Baldwin, Jared G., M.D., 8 E. 41st St., New York.
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1865. Beckwith, D. H., M.D., Cleveland, O.
1871. Beckwith, E. C., M.D., Columbus, O.
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1870. Beebe, E. W. M.D., Milwaukee, Wis.
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1867. Bell, James S., M.D., Cedar Falls, Iowa.
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1869. Bevin, William A., M.D., Trenton, N. J.
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1876. Bigler, William H., M.D., 118 N. 12th Street, Philadelphia, Pa.
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1880. Boardman, Horace E., M.D., Monroe, Wis.
1865. Boericke, F. E., M.D., 635 Arch St., Philadelphia, Pa.
1874. Bond, Mary E., M.D., 122 Lexington Av., New York.
1880. Boothby, Alonzo, M.D., 19 Joy St., Boston, Mass.
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1871. Bradford, Herbert C., M.D., Lewiston, Me.
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1872. Brown, Samuel, M.D., 651 N. 10th St., Philadelphia.
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1867. Campbell, C. E., M.D., 314 E. 18th St., New York.
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1867. Cook, E. G., M.D., 103 State Street, Chicago, Ill.
1874. Coon, Henry C., M.D., Alfred Centre, N. Y.
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1876. Couch, Louis B., M.D , Nyack, N. Y.
1869. Covert, Nelson B., M.D., Geneva, N. Y.
1871. Covert, Rynear B., M.D., Seneca Falls, N. Y.
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1878. Cranch, Edward, M.D., Erie, Pa.
1874. Crank, C. D., M.D., Cincinnati, O.
1872. Crater, Henry, M.D., Somerville, N. J.
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1876. Crocket, Frederick E., M.D., West Newton, Mass.
1876. Crosby, Obed H., M.D., Atlantic City, N. J.
1869. Cross, Hiram B., M.D., Jamaica Plain, Mass.
1875. Cross, Lester E., M.D., Stockton, Cal.
1869. Cross, William P., M.D., 476 Broadway, South Boston, Mass.
1859. Cullis, Charles, M.D., 16 Somerset St., Boston, Mass.
1867. Currier, C. B., M.D., N. Y. City.
1876. Curtis, John M., M.D., Wilmington, Del.
1874. Curtis, R. J., M.D., Mayville, N. Y.
1867. Cushing, Alvan M., M.D., Lynn, Mass.
1878. Cushing, Chas. F., M.D., Elyria, O.
1879. Custis, J. B. G., M.D., 604 E. Capitol St., Washington, D. C.
1869. Cutler, William C., M.D., Chelsea, Mass.
1866. Dake, B. F., M.D., Pittsburg, Pa.
1877. Dake, Walter M., M.D., Nashville, Tenn.
1872. Dake, William C., M.D., Nashville, Tenn.
1879. Dake, J. Percy, M.D., Nashville, Tenn.
1879. Danforth, L. L., M.D., 158 W. 44th St., N. Y. City.
1870. Danforth, Willis, M.D., 425 Milwaukee St., Milwaukee, Wis.
1874. Darling, Henry H., M.D., Keene, N. H.
1875. Dart, George, M.D., Sacramento, Cal.
1871. Davis, W. Beesley, M.D., 323 Richmond Street, Philadelphia.
1875. Davis, Fielding L., M.D., Evansville, Ind.
1878. Davis, John E. L., M.D., Nyack, N. Y.
1868. Dayfoot, Herbert M., M.D., Mount Morris, N. Y.
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1875. Deschere, Martin, M.D., 254 W. 25th St., New York.
1858. Detwiler, J. J., M.D., Easton, Pa.
1878. Dinsmore, Samuel W. S., M.D., Sharpsburg, Pa.
1876. Dixon, George M., M.D., Sacramento, Cal.
1875. Dodge, Rodolph L., M.D., Portland, Me.
1875. Doolittle, Egbert D., M.D., New Brunswick, N. J.
1880. Donaldson, Samuel J., M.D., Portsmouth, N. H.
1868. Doran, Charles R., M.D., Jacksonville, Florida.
1869. Dorion, Charles N., M.D., St. Paul, Minn.
1872. Doughty, Francis E., M.D., 46 W. 33d St., N. Y.
1867. Dowling, John W., M.D., 313 Madison Av., N.Y.
1875. Drake, Harlow B., M.D., Detroit, Mich.
1871. Drake, Jason W., M.D., Dover, N. H.
1871. Drake, Olin M., M.D., Ellsworth, Me.
1871. Dreher, Charles B., M.D., Tamaqua, Pa.
1869. Dudley, Pemberton, M.D., S. W. cor. 15th and Master Sts., Philadelphia.
1866. Duncan, T. C., M.D., 133 S. Clark St., Chicago.
1874. Dunn, J. L., M.D., Titusville, Pa.
1866. Earhart, J. R., M.D., 23 N. 19th St., Philadelphia.
1877. Eastman, Frank, M.D., Atlanta, Ga.
1859. Eaton, Hosea B., M.D., Rockport, Me.
1877. Eaton, J. Albro, M.D., 67 Putnam Av., Brooklyn, New York.
1880. Eaton, Morton M., M.D., 120 W. 7th St., Cincinnati, O.
1876. Eckel, John N., M.D., 324 Geary St., San Francisco, Cal.
1874. Edmonds, Wm. A., M.D., 2924 Washington Av., St. Louis, Mo.
1871. Edmundson, Walter F., M.D., 375 Fifth Av., Pittsburg, Pa.
1872. Edson, Susan A., M.D., 1308 I St., N. W., Washington, D. C.
1868. Eggert, William, M.D., Indianapolis, Ind.
1869. Elliott, Joseph B., M.D., 493 Clinton Av., Brooklyn, N. Y.
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1873. Ensign, Jennie, M.D., 357 W. 34th St., New York.
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1871. Fetterhoff, Hiram R., M.D., 77 George St., Baltimore, Md.
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1870. Gottschalk, Wm. von, M.D., 243 Westminster St., Providence, R. I.
1869. Gramm, Gustavus E., M.D., 1656 Vienna St., Philada.
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1869. Griffith, J. J., M.D., 173 Green Lane, Manayunk, Philadelphia.
1872. Griswold, W. N., M.D., 203 Powell St., San Francisco, Cal.
1877. Griveaud, E. A., M.D., 1400 Olive St., St. Louis, Mo.
1869. Groot, S. I., M.D., 724 New York Ave., Washington, D. C.
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1876. Guernsey, Wm. Jefferson, M.D., 4431 Frankford Ave., Philadelphia.
1874. Guernsey, W. N., M.D., 59 W. 26th St., New York.
1867. Gumpert, B. B., M.D., 840 Franklin St., Philadelphia.
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1874. Hall, Robert, M.D., Providence, R. I.
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1876. Harpel, Edward N., M.D., Pottsville, Pa.
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1875. Hasbrouck, Everett, M.D., 253 13th St., Brooklyn, New York.
1878. Hastings, Caroline E., M.D., 145 W. Concord St., Boston, Mass.
1857. Hatch, Philo L., M.D., Minneapolis, Minn.
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1867. Hinds, W. H. W., M.D., Milford, N. H.
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1879. Hoag, Clitus S., M.D., Waterbury, Vt.
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1876. Hoppins, Henry S., M D., Geneseo, Ill.
1867. Hornby, John, M.D., Poughkeepsie, N. Y.
1858. Hotchkiss, Jesse T., M.D., Cornwall, Orange Co., N. Y.
1859. Houghton, H. A., M.D., 193 Main St., Boston.
1867. Houghton, Henry C., M.D., 44 W. 35th St., New York.
1875. House, Robert B., M.D., Tecumseh, Mich.
1870. Hoxsie, Augustus C., M.D., 121 Franklin St., Buffalo, N. Y.
1869. Huebener, O. T., M.D., Litiz, Pa.
1869. Humphrey, Otis M., M.D., Minneapolis, Minn.
1867. Hunt, Henry F., M.D., 315 Market St., Camden, New Jersey.
1873. Hunt, J. B , M.D., Delaware, O.
1874. Hunt, Dwight B., M.D., 50 W. 29th St., New York.
1873. Hurd, Edwin H., M.D., cor. Sophia and Allen Sts., Rochester, N. Y.
1871. Hunting, Nelson, M.D., Albany, N. Y.
1872. Hutchins, H. S., M.D., Batavia, N. Y.
1867. Ingalls, Frederic W., M.D., Kingston, N. Y.
1876. Jackson, Edward R., M.D., Dubuque, Iowa.
1878. Jackson, Wm. H. H., M.D , Oil City, Pa.
1878. Jackson, W. L., M.D., 84 Dudley St., Boston, Mass.
1878. Janney, Frances G., M.D., Columbus, O.
1859. James, Bushrod W., M.D., N. E. cor. 16th and Green Sts., Philadelphia.
1866. James, J. E., M.D., N. W. corner 10th and Green Sts., Philadelphia.
1867. Jayne, De Witt C., M.D., Florida, N. Y.
1859. Jefferds, George P., M.D., Bangor, Me.
1875. Jenks, George Henry, M.D., 7 O'Farrell St., San Francisco, Cal.
1873. Jenney, William H., M.D., Kansas City, Mo.
1869. Jernegan, H. Mayhew, M.D., 133 W. Newton St., Boston, Mass.
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1874. Jones, Charles E., M.D., Albany, N. Y.
1873. Jones, Gaius J., M.D., Cleveland, O.
1867. Jones, Henry C., M.D., Mount Vernon, N. Y.
1858. Jones, Joseph E., M.D., West Chester, Pa.
1875. Jones, Leonidas M., M.D., Brooklyn, Mich.
1868. Jones, S. A., M.D., Ann Arbor, Mich.
1867. Jones, William A., M.D., Wilton, N. H.
1876. Kanouse, Abijah W., M.D., Lancaster, Wis.
1867. Keep, J. Lester, M.D., 460 Clinton Av., Brooklyn, N. Y.
1874. Keep, Caroline J. Yeomans, M.D., 469 Vanderbilt Av., Brooklyn, N. Y.
1869. Keith, Theo. S., M.D., Newton, Mass.
1858. Kellogg, Edwin M., M.D., 257 Broadway, New York.
1880. Kenyon, Claudius B., M.D., Rock Island, Ill.
1874. Kenyon, William B., M.D., Buffalo, N. Y.
1879. Kern, George W., M.D., Johnstown, Pa.
1874. Kern, William H. H., M.D., McKeesport, Pa.
1870. King, E. H., M.D., Clinton, Iowa.
1869. Kinne, Theodore Y., M.D , Paterson, N. J.
1876. Kinne, Porter S., M.D., Paterson, N. J.
1870. Kippax, John R., M.D., Chicago, Ill.
1879. Kirkland, Wm. H., M.D., Massillon, O.
1869. Kittinger, Leonard, M.D., Wilmington, Del.
1875. Klein, John W., M.D., 207 3d St., Louisville, Ky.
1874. Knapp, Theodore P., M.D., Union, N. Y.
1871. Kneass, Nicholas W., M.D., Baltimore, Md.
1871. Knerr, Calvin B., M.D., 112 N. 12th St., Philadelphia.
1875. Knickerbocker, Simeon C., M.D., Watertown, N. Y.
1867. Knight, Elam C., M.D., Leominster, Mass.
1875. Korndœrfer, Augustus, M.D., 648 N. 12th St., Philadelphia.
1865. Krebs, Francis H., M.D., 42 Union Park, Boston, Mass.
1874. Laird, William T., M.D., Augusta, Me.
1872. Lawton, C. H., M.D., Wilmington, Del.
1873. Leonard, W. H., M.D., Minneapolis, Minn.
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1867. Lilienthal, S., M.D., 230 W. 25th St., New York.
1874. Linnell, Jonathan E., M.D., Norwich, Conn.
1858. Lougee, William H., M.D., Lawrence, Mass.
1876. Lounsberry, Osmer W., M.D., Cincinnati, O.
1868. Ludlam, Edward M. P., M.D., 318 W. Washington St., Chicago, Ill.
1857. Ludlam, Reuben, M.D., 526 Wabash Av., Chicago, Ill.
1872. Lukens, Isaiah, M.D., Newport, Del.
1870. Lungren, Samuel S., M.D., Toledo, O.
1860. McClatchey, R. J., M.D., 918 N. 10th St., Philadelphia, Pa.
1879. McClelland, John B., M.D., 319 Penn Av., Pittsburg, Pa.
1867. McClelland, J. H., M.D., 319 Penn Av., Pittsburg, Pa.
1879. McCrea, Philip A., M.D., East Aurora, N. Y.
1873. McDermott, George C., M.D., Cincinnati, O.
1874. McDonald, William O., M.D., 24 W. 29th St., N. Y.
1875. McGuire, David J., M.D., Detroit, Mich.
1868. Macfarlan, Malcolm, M.D., 1805 Chestnut St., Philada.
1871. McGeorge, Wallace, M.D., Woodbury, N. J.
1866. McMurray, Robert, M.D., 234 Second Av., New York.
1867. Macomber, Addison P., M.D., Atlantic, Iowa.
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1867. Mandeville, F. B., M.D., Newark, N. J.
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1880. Manning, Caroline E., M.D., Clifton House, Chicago, Ill.
1871. Martin, Constantine H., M.D., Allentown, Pa.
1868. Martin, H. N., M.D., 500 N. 18th St., Philadelphia.
1876. Martin, Samuel J., M.D., Racine, Wis.
1878. Martin, W. J., M.D., 1708 Carson St., Pittsburg, Pa.
1867. Mason, S. R., M.D., Devall's Bluff, Ark.
1859. Matthes, G. Felix, M.D., New Bedford, Mass.
1880. Maxon, Joseph S., M.D., Walworth, Wis.
1871. Mercer, Robert P., M.D., Chester, Pa.
1876. Mercer, William M., M.D., Galveston, Texas.
1871. Middleton, Caleb S., M.D., 646 N. 10th St., Philadelphia.
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1880. Mirrick, Myra K., M.D., Cleveland, O.
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1866. Mitchell, John J., M.D., Newburgh, N. Y.
1875. Mitchell, John N., M.D., 1733 Chestnut St., Philada.
1866. Mitchell, J. S., M.D., 817 Michigan Av., Chicago.
1867. Moffat, Reuben C., M.D., 17 Schermerhorn St., Brooklyn, N. Y.
1876. Mohr, Chas., M.D., 555 N. 16th St., Philadelphia, Pa.
1876. Monmonier, Julius L., M.D., 128 Greene Av., Brooklyn, N. Y.
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1876. Moore, J. Murray, M.D., 12 Morant St., Taunton, England.
1868. Moore, John, M.D., Liverpool, England.
1860. Moore, Thomas, M.D., N. E. cor. West Walnut Lane and Green St., Germantown, Philadelphia.
1867. Morgan, John C., M.D., 1706 Green St., Philadelphia, Pa.
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1872. Morse, Lucius D., M.D., Memphis, Tenn.
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1869. Mosman, Nathan A., M.D., 6 E. 34th St., New York.
1880. Moss, Oscar B., M.D., 385 Euclid Av., Cleveland, O.
1859. Munde, Charles, M.D., Wurzburg, Germany.
1877. Murphy, Edmund A., M.D., New Orleans, La.
1875. Murrell, William J., M.D., Mobile, Ala.
1867. Negendank, Augustus, M.D., Wilmington, Del.
1872. Nichol, Thomas, M.D., Montreal, Dominion of Canada.
1876. Nichols, Ammi S., M.D., Walla Walla, Washington Territory.
1880. Nichols, Charles L., M.D., Worcester, Mass.
1874. Nichols, C. F., M.D., Boston, Mass.
1867. Nichols, Frank, M.D., Hoboken, N. J.
1876. Nichols, George, M.D., 230 Leonard Street, Brooklyn, New York.
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1856. Ormes, Cornelius, M.D., Jamestown, N. Y.
1879. Osborne, Nehemiah, M.D., Buffalo, N. Y.
1876. Ostrom, Homer I., M.D., 229 W. 23d St., New York.
1865. Owens, William, M.D., corner 7th and John Sts., Cincinnati, O.
1878. Owens, William, Jr., M.D., Puerte Berrio, U. S. of Colombia, S. A.
1868. Packard, Liberty D., M.D., 538 Broadway, South Boston, Mass.
1869. Page, Moses F., M.D., Appleton, Wis.
1856. Palmer, Fred. N., M.D., 8 Bullfinch Place, Boston, Mass.
1875. Palmer, George H., M.D., St. Clair, Mich.
1879. Parsons, Katherine, M.D., Cleveland, O.
1873. Patchen, George H., M.D., Burlington, Iowa.
1870. Patchen, T. J., M.D., Fond du Lac, Wis.
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1879. Payne, George H., M.D., 1508 Washington St., Boston, Mass.
1860. Payne, James H., M.D., 1472 Washington St., Boston, Mass.
1879. Payne, Mary A., M.D., Dover, N. H.
1867. Pearsall, S. J., M.D., Saratoga Springs, N. Y.
1867. Pearson, Clement, M.D., 608 12th St., Washington, D. C.
1875. Pearce, Robert W., M.D., 213 3d St., Louisville, Ky.
1868. Pease, Giles M., M.D., 125 Turk St., San Francisco, Cal.
1874. Pease, Giles, M.D., Rockville, Conn.
1868. Peck, Edwin H., M.D., Cleveland, O.
1879. Peck, George B., M.D., Providence, R. I.
1872. Peer, George W., M.D., Rochester, N. Y.
1877. Penfield, Sophia, M.D., Danbury, Conn.
1870. Pennoyer, N. A., M.D., Kenosha, Wis.
1858. Perrine, W. L. R., M.D., 137 Montague St., Brooklyn, N. Y.
1873. Pettet, Jonathan, M.D., Cleveland, O.
1872. Pettingill, Eliza F., M.D., 300 N. Tenth St., Philadelphia.
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1880. Pitcairn, Hugh, M.D., Harrisburg, Pa.
1874. Plimpton, Clara C., M.D., Nashville, Tenn.
1877. Pond, John N., M.D., Meadville, Pa.
1876. Pope, Gustavus W., M.D., Washington, D. C.
1880. Porter, Philip, M.D., 29 Lafayette Av., Detroit, Mich.
1879. Potter, S. O. L., M.D., Milwaukee, Wis.
1867. Poulson, P. W., M.D., Council Bluffs, Iowa.
1880. Poulson, Haraldt Ludwig, M.D., Council Bluffs, Iowa.
1871. Powell, H., M.D., 184 East Broadway, New York.
1867. Pratt, Leonard, M.D., Wheaton, Ill.
1859. Pratt, L. M., M.D., 104 State St., Albany, N. Y.
1874. Pratt, William M., M.D., 204 East 15th St., New York.
1867. Pratt, E. H., M.D., 73 Randolph St., Chicago, Ill.
1876. Pratt, John W., M.D., Coatesville, Pa.
1866. Preston, Coates, M.D., Chester, Pa.
1871. Preston, Mahlon, M.D., Norristown, Pa.
1867. Price, Elias C., M.D., 262 Madison Av., Baltimore, Md.
1876. Price, Emmor H., M.D., Chattanooga, Tenn.
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1877. Quirell, C. A., M.D., 33 Westey Av , Cincinnati, O.
1865. Rankin, John S., M.D., Pittsburg, Pa.
1869. Raue, Charles G., M.D., 121 N. 10th St., Philadelphia.
1860. Reading, Edward, M.D., Hatboro, Pa.
1857. Reed, William A., M.D., 123 N. 11th St., Philadelphia.
1870. Reynolds, William B., M.D., Newville, Pa.
1877. Rice, Alvin B., M.D., Panama, N. Y.
1869. Richards, George W., M.D., Orange, N. J.
1872. Richardson, B. M., M.D., Hoffman House, New York.
1876. Richardson, William C., M.D., St. Louis, Mo.
1880. Roche, Edward P., M.D., Bath, Me.
1875. Robertson, George A., M D., Chelsea, Mich.
1873. Robertson, E. W., M.D., Cleveland, O.
1869. Robinson, Charles F., M.D., 83 Saratoga St., E. Boston, Mass.
1875. Robinson, John T., M.D., Warsaw, Ky.
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1875. Runnels, Moses T., M.D., Indianapolis, Ind.
1873. Runnels, O. S., M.D., Indianapolis, Ind.
1865. Rush, R. B., M.D., 120 Main St., Salem, O.
1880. Rushmore, Edward, M.D., Plainfield, N. J.
1880. Russeque, Henry E., M.D., South Framingham, Mass.
1872. Safford, Mary J., M.D., 3 Hamilton Place, Boston, Mass.
1869. Sage, William H., M.D., New Haven, Conn.
1860. Sanders, John C., M.D., Cleveland, O.
1859. Sanders, Orren S., M.D., 511 Columbus Av., Boston, Mass.
1867. Sanford, Charles E., M.D., Bridgeport, Conn.
1869. Sanger, Thaddeus E., M.D., Littleton, N. H.
1871. Sargent, Rufus, M.D., 1609 Mt. Vernon St., Philadelphia.
1871. Sartain, Harriet J., M.D., 210 Franklin St., Philadelphia.
1867. Sawin, Isaac W., M.D., Providence, R. I.
1878. Sawyer, Alfred I., M.D., Monroe, Mich.
1867. Scales, Edward P., M.D., Newton, Mass.
1859. Scales, Thomas S., M.D., Woburn, Mass.
1874. Schenck, Benjamin B., M.D., Plainville, N. Y.
1874. Scherzer, William, M.D , 31 W. 31st St., New York.
1873. Scheurer, E. M., M.D., Clearfield, Pa.
1875. Schley, James Montford, M.D., 1 E 42d St., New York.
1873. Schmucker, Elhanan Z., M.D., Reading, Pa.
1868. Schneider, N., M.D., Cleveland, O.
1872. Scott, Chester W., M.D., Lawrence, Mass.
1867. Seeley, N. R., M.D., Elmira, N. Y.
1868. Seidlitz, George N., M.D., Keokuk, Iowa.
1869. Seip, C. P., M.D., 260 Penn Av., Pittsburg, Pa.
1875. Selfridge, James M., M.D., Oakland, Cal.
1876. Seward, John L., M.D., Orange, N. J.
1874. Seymour, Abby J., M.D., Buffalo, N. Y.
1867. Shaffer, Levi, M.D., Kingston, N. Y.
1879. Shannon, Samuel F., M.D., Pittsburg, Pa.
1875. Shaw, George R., M.D., Ripon, Wis.
1867. Shearer, Thomas, M.D., 97 N. Charles St., Baltimore, Md.
1870. Sheldon, J. W., M.D., Syracuse, N. Y.
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1859. Sherman, John H., M.D., 550 Broadway, South Boston, Mass.

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1879. Slocum, Royal, M.D., Easton, N. Y.
1876. Slough, Frank J., M.D., Allentown, Pa.
1873. Smith, Chester, M.D., Portland, Mich.
1870. Smith, Franklin B., M.D., Owosso, Mich.
1860. Smith, Henry M., M.D., 107 Fourth Ave., New York.
1879. Smith, J. Edwards, M.D., Cleveland, O.
1869. Smith, J. Heber, M.D., Melrose, Mass.
1876. Smith, John Miller, M.D., Lafayette, Ind.
1869. Smith, St. Clair, M.D., 11 E. 38th St., New York.
1860. Smith, Thomas F., M.D., 62 E. 128th St., New York.
1867. Sommer, G. J. M., M.D., 119 2d St., New York.
1871. Southwick, Augustus B., M.D., Rome, N. Y.
1868. Southwick, D. E., M.D., Ogdensburg, N. Y.
1874. Sovereign, Baxter, M.D., Arcade, N. Y.
1869. Spalding, Henry E., M.D., Hingham, Mass.
1859. Sparhawk, George E. E., M.D., Burlington, Vt.
1877. Speakman, Rachel T., M.D., Clifton House, Chicago, Ill.
1875. Spinney, Andrew B., M.D., Detroit, Mich.
1878. Spranger, Francis X., M.D., Detroit, Mich.
1871. Stiles, James E., M.D., Lambertville, N. J.
1858. Stone, Henry E., M.D., Fairhaven, Conn.
1879. Stone, Martha M., M.D., Cleveland, O.
1880. Storke, Eugene F., M.D., Milwaukee, Wis.
1869. Stow, T. Dwight, M.D., Syracuse, N. Y.
1871. Streets, Jacob G., M.D., Bridgeton, N. J.
1869. Strong, O. G., M.D., Canton, Ill.
1880. Strong, T. M., M.D., Allegheny City, Pa.
1876. Sumner, Albert E , M.D., 150 Joralemon St., Brooklyn, N. Y.
1865. Sumner, Charles, M.D., 14 S. Clinton St., Rochester, N. Y.
1880. Swain, Mary L., M.D., Minneapolis, Minn.
1867. Swan, Samuel, M.D., 13 W. 38th St., New York.
1879. Swartz, J. Ross, M.D., Harrisburg, Pa.
1874. Swift, Charles E., M.D., Auburn, N. Y.
1880. Swift, Mayhew, M.D., 313 Madison Ave., New York, N. Y.
1867. Swift, Solomon E., M.D., Colchester, Conn.
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1875. Terry, Marshall O., M.D., Utica, N. Y.
1869. Thomas, Amos R., M.D., 1733 Chestnut St., Philadelphia, Pa.
1875. Thomas, Charles M., M.D., 1313 Arch St., Philadelphia.
1871. Thomas, William W., M.D., Wilmington, Del.
1867. Thompson, John H., M.D., 36 E. 30th St., New York.
1867. Thompson, Virgil, M.D., 169 W. 12th St., New York.
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1869. Trites, William Budd, M.D., 4323 Main St., Manayunk, Philadelphia.
1877. Tucker, Samuel G., M.D., Oakland, Cal.
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1875. Underwood, Helen J., M.D., 591 Wabash Av., Chicago, Ill.
1876. Vail, John D., M.D., Montrose, Pa.
1875. Valentine, Philo G., M.D., St. Louis, Mo.
1873. Van Norman, E. V., M.D., Springfield, O.
1870. Van Norman, H. B., M.D., 201 Pearl St., Cleveland, O.
1876. Van Vleck, Peter H., M.D., Sturgis, Mich.
1876. Varona, Adolph, M.D., 108 Joralemon St., Brooklyn, N. Y.
1858. Verdi, Tullio S., M.D., 901 16th St., N. W., Washington, D. C.
1877. Vilas, C. H., M.D., 56 E. Washington St., Chicago.
1871. Vincent, Frank L., M.D., Troy, N. Y.
1876. Vincent, John A., M.D., Springfield, Ill.
1874. Waite, Phœbe J. B., M.D., Blind Asylum, 9th Av. near 34th St., New York.
1880. Walker, George S., M.D., 2809 Washington Av., St. Louis, Mo.
1869. Walker, Mahlon M., M.D., 12 W. Walnut Lane, Germantown, Philadelphia.
1865. Wallace, M. W., M.D., Allegheny City, Pa.
1872. Walter, Ziba D., M.D., Marietta, O.
1874. Walton, Charles E., M.D., Hamilton, O.
1874. Ward, A. F., M.D., Jamestown, N. Y.
1872. Ward, James H., M.D., 60 Bedford Av., Brooklyn, N. Y.
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1871. Wentworth, Walter H., M.D., Pittsfield, Mass.
1866. Werder, Max J., M.D., 36 Geary St., San Francisco, Cal.
1859. Wesselhœft, Conrad, M.D., 302 Columbus Av., Boston, Mass.
1867. Wesselhœft, Walter, M.D., Cambridge, Mass.
1859. Wesselhœft, William P., M.D., 52 Boylston St., Boston, Mass.
1869. West, Benjamin H., M.D., Neponset, Mass.
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1873. West, James A., M.D., Geneseo, N. Y.
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1874. Wheaton, James L., M.D., Pawtucket, R. I.
1876. Wheeler, Byron H., M.D., Denver, Col.
1879. Whitcomb, Fidelia J. M., M.D., Nunda, N. Y.
1867. White, J. Ralsey, M.D., 228 E. 124th St., New York.
1860. White, Theodore C., M.D., 21 S. Clinton St., Rochester, N. Y.
1867. White, W. Hanford, M.D., 307 5th Av., New York.
1873. Whitfield, Isaiah J., M.D., Grand Rapids, Mich.
1868. Whiting, S. C., M D , Laporte, Ind.
1869. Whittier, Daniel B., M D., Fitchburg, Mass.
1867. Whittle, James P., M.D., Weare, N. H.
1859. Wild, Edward A., M.D., Austin, Nevada.
1876. Wildes, Thomas, M.D., 35 W. 31st St., New York.
1867. Willard, L. H., M.D., Allegheny, Pa.
1876. Williams, Adaline, M.D., St Charles, Minn.
1880. Williams, D. R., M.D., Woodhull, Wis.
1876. Williams, Nancy T., M.D., Gardiner, Me.
1871. Williams, Thomas C., M.D., 567 N. 5th St., Philadelphia.
1876. Williamson, Alonzo P., M.D., Ward's Island, N. Y. City.
1872. Williamson, Matthew S., M.D., 29 N. 11th St., Philada.
1859. Wilson, G. H., M.D., Meriden, Conn.
1876. Wilson, Joseph H., M.D., Bellefontaine, O.
1865. Wilson, T. P., M.D., Ann Arbor, Mich.
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